Leveraging the Strengths of Psychologists with Lived Experience of Psychopathology

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Abstract

Psychopathology is a common element of the human experience, and psychological scientists are not immune. Recent empirical data demonstrate that a significant proportion of clinical, counseling, and school psychology faculty and graduate students have lived experience, both past and present, of psychopathology (Victor et al., in press). This commentary compliments these findings by leveraging the perspectives of the authors and signatories, with personal lived experience of psychopathology, to improve professional inclusivity within these fields. By "coming out proud" (Corrigan et al., 2013), the authors aim to foster discussion, research, and inclusion efforts as they relate to psychopathology experiences within psychological science. To that end, the authors describe considerations related to disclosure of lived experience, identify barriers to inclusion, and provide concrete recommendations for personal and systemic changes to improve recognition and acceptance of psychopathology lived experience among psychologists.

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1. Introduction

Psychopathology[1] is incredibly common at the population level, and recent national and global stressors (e.g., COVID-19 pandemic, racialized violence, and intergenerational trauma) further highlight its prevalence and importance. In the United States, research indicates that about half of individuals will experience psychopathology at some point in their lifetime (Kessler et al., 2005); longitudinal cohort studies elsewhere find prevalence rates of 86% by midlife (Caspi et al., 2020). Despite these figures, psychopathology remains highly stigmatized (e.g., Krendl et al., 2020; Pescosolido et al., 2019). Although psychologists routinely champion anti-stigma efforts and awareness campaigns (Corrigan, 2016; see examples, Rao et al., 2019), psychological scientists and practitioners rarely publicly acknowledge their own lived experiences with psychopathology.

There are surprisingly few published narratives detailing lived psychopathology experiences written by academic or practicing clinical, counseling, or school psychologists (hereafter referred to as applied psychologists; for notable examples, see Hinshaw, 2017; Linehan, 2021; Redfield Jamison, 1996; Rottenberg, 2014). Likewise, little to no empirical data are available on prevalence of psychopathology among those in applied psychology professions. This commentary draws upon empirical data from Victor et al. (in press) by offering a review of prior literature, along with personal perspectives and insights from applied psychology professionals—including trainees and faculty—with lived experience of past and/or present psychopathology. Accordingly, we aim to foster discussion, research, and inclusion efforts to improve conditions for psychology trainees and faculty with personal experience of psychopathology.

The commentary authors and signatories have agreed to the following positionality statement in order to contextualize our joint efforts and consider how our relative positions of power and societal standing inevitably shape our perspective herein (e.g., Bourke, 2014).

> *We, the authors and signatories, have personal lived experience of psychopathology. Further, we have felt, feared, or witnessed adverse consequences related to stigma towards psychopathology in our professional training and careers. We recognize the need for substantial change within the fields of applied psychology with respect to how lived experience is recognized and addressed. Finally, we believe that acknowledging lived experience of psychopathology within our professional community—specifically, among those working to understand and reduce it—is an integral component of efforts to improve diversity, equity, and inclusion within psychological science.[2]*

Perhaps most importantly, we argue that a culture that facilitates open discussions of lived experience of psychopathology among psychologists themselves is a *necessary prerequisite* for fostering professional inclusivity. Importantly, these conversations must be started and encouraged by psychologists with relative professional power, including tenured and tenure-track faculty members. Beyond being mentors, trainers, and role models, psychology faculty are de-facto gatekeepers for our field's future workforce. In both implicit and explicit ways, the words and actions of well-intentioned faculty may foster internalized stigma and discourage help-seeking among students and colleagues. By "coming out proud" (Corrigan et al., 2013), we hope this commentary provides a personal connection to the empirical data presented in the companion paper. Thus, we aim to decrease stigma within the field, catalyze overdue self-reflection, and show more junior trainees that success within academia is possible for people who currently live, or have lived, with psychopathology in their own lives. Beyond encouraging discussion, we hope this commentary facilitates critical changes in the field's recognition and acceptance of lived experience among psychologists.

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[1] A variety of terms have been used to indicate mental health difficulties, including mental illness, mental disorder, and psychiatric diagnoses. In this manuscript, the term "psychopathology" will be used for brevity to refer to these experiences more broadly.

[2] Signatories are faculty members in applied psychological sciences (clinical, counseling, and/or school psychology) within the US or Canada. Specific positionality information for the authors is provided in the acknowledgements. The complete list of signatories is available online at <redacted for preprint until manuscript is published>

2. The Need for Dialogue on Lived Experience of Psychopathology in Psychologists

The need to initiate a discipline-wide dialogue on lived experience of psychopathology among applied psychologists contains (at least) three facets. First, psychologists serve as role models for society at large—particularly with respect to how psychopathology is best understood, evaluated, and treated. By addressing stigma about psychopathology occurring within our own professional community, we can begin to publicly normalize attitudes towards and conversations about mental health and illness.

Second, openly acknowledging our own positionality is critical for conducting rigorous science. This necessity is generally recognized within the social sciences and humanities (e.g., Bourke, 2014; England, 1994) and is increasingly acknowledged even in traditional STEM disciplines such as engineering (Secules et al., 2021). And yet, questions of positionality are often neglected and even overtly dismissed within psychological science (Nzinga et al., 2018), despite the fact that our discipline deals directly with human experience, and *all* researchers studying human beings have life experiences that interact with and inevitably influence their work. Naming and engaging with our positionalities—including lived psychopathology experience, *and* the absence of such experience, which each confer distinct perspectives—allows us to better contextualize our work, and to highlight the viewpoints our science may integrate.

Third, faculty in accredited applied psychology programs often engage in clinical supervision, and a majority of trainees in these programs pursue careers involving clinical practice (American Psychological Association, 2016). Ethical clinical practice requires awareness of one's functioning and maintenance of well-being; inherently, this goal requires programs to educate trainees on the importance of considering one's own psychological functioning and well-being, particularly as it relates to clinical obligations.

3. Guiding Assumptions and Beliefs

To contextualize our reflections, experiences, and recommendations, and toward facilitating respectful dialogue around topics that are sensitive for many, we wish to clarify our positions and beliefs that guide this commentary.

1. Lived experience of psychopathology—including psychopathology characterized as "severe"—is *not* an insurmountable barrier to success in academic psychology.
We recognize that psychopathology involves distress and/or impairment, which can influence work functioning and professional productivity—similar to physical health conditions. Thus, approaches that gauge professional fitness in the context of psychopathology should parallel approaches related to physical health conditions (e.g., cancelling therapy sessions due to physical illness is viewed as protective of clients, not a sign of professional unfitness; mental health conditions should be no different).

2. Lived experience of psychopathology is neither necessary nor sufficient to provide effective clinical care, be an effective mentor, or conduct rigorous research.
People who have experienced psychopathology are not professionally "superior" to people without such experience; rather, people *with* lived experience of psychopathology should *not* be viewed as professionally "inferior" to those without. As in all disciplines, diverse perspectives are necessary for our work to fully represent the populations we serve and study.

3. One's lived psychopathology experience may or may not relate to one's clinical or research expertise.
It is inappropriate to garner assumptions regarding a person's experiences and/or identities on the basis of their professional work—i.e., the "research is me-search" stereotype—whether that assumption is that they do, or do not, have direct lived experience of the specific conditions they study. The relevance of understanding the impact of one's lived experience on psychological practice is strongly embedded in certain theoretical traditions, including psychoanalytic and dynamic

orientations, which emphasize the importance of personal therapy for psychologists to identify domains in which the clinician's own lived experiences could adversely impact their understanding of, or responses to, the experiences of their clients (American Psychoanalytic Association, 2021).

4. Disclosure of psychopathology should not be expected or coerced among psychologists.
We perceive potential personal and societal benefits to disclosure, *and,* disclosing one's lived psychopathology experience is a highly personal decision at any career stage. Disclosure is not always or necessarily the right choice for everyone, or under all circumstances.

5. Lived experience of psychopathology may bias a psychologist's practice and research— just as *all* aspects of a person's identity and life experiences do.
Thoughtful self-reflection on one's professional biases is necessary to understand and, potentially, address them. However, assuming that psychopathology uniquely undermines one's capacity to examine, identify, and manage personal biases in an objective manner is unfounded. Although openness about one's potential biases can counter their pernicious effects (e.g., Patton, 2002; Peshkin, 1988), such openness is only possible if people with lived experience of psychopathology can, at a minimum, safely acknowledge their experiences in professional settings.

6. Experiences of psychopathology among psychologists vary tremendously.
No two experiences of psychopathology are the same. Likewise, harm related to one's psychopathology may intersect with harms experienced on the basis of other marginalized identities, such as those linked to race/ethnicity, religion, sexual orientation, gender, non-psychiatric disabilities, or socioeconomic resources. Furthermore, the variation in stigma and associated discrimination that differs depending on severity and acceptability of different mental health diagnoses will shape the nature of people's lived experiences of psychopathology.

Taken together, this commentary was written according to the principles outlined above, along with the authors' first-hand experiences, both past and present, navigating personal psychopathology in varied contexts. Thus, the examples and recommendations provided are non-exhaustive and will benefit from continued, collaborative, and inclusive consideration looking forward.

4. The Lived Experience of Psychopathology Within Psychology
Contextual and individual variability notwithstanding, many trainees and faculty with lived psychopathology experience share some overlapping challenges and concerns. First, many barriers exist to accessing treatment during professional training. These include low stipends (particularly for graduate students and postdoctoral fellows), variable or limited insurance coverage for mental health care, and overlap between clinical training sites and professional relationships with high-quality treatment options. Indeed, given mental health care provider shortages that pervade the United States and Canada, finding clinicians who are not also potential supervisors, collaborators, or colleagues can be challenging for applied psychologists at all career stages. Compounding these barriers, most trainees move multiple times before obtaining a stable position—including for graduate school, predoctoral internship, postdoctoral training, and post-baccalaureate research positions that have become increasingly important for gaining admission to doctoral programs. The expectation of geographic flexibility carries seldom-discussed stressors and consequences for trainees with psychopathology, who may lose access to critical support systems with each move. Trainees may also become tasked with coordinating uninterrupted care with new providers; endure waiting periods for access to health insurance that interrupt needed treatment; and undergo financial strain and stress during each transition.

Within training programs themselves, policies designed to support trainees with psychopathology are often lacking. The dearth of programmatic policies around accommodations for psychopathology leads many to manage their treatment in secret and independently, even when institutional accommodations would be appropriate. For example, departmental policies regarding leaves of absence are often vague (e.g., when they are allowable; how long they may last; how readiness to return is ascertained; how will it affect teaching or research stipends). In the United States, leaves of absence can result in a loss of stipends, health insurance coverage, or both—rendering needed

treatment impossible to access. Furthermore, federal policies designed to address this problem (e.g., Family and Medical Leave Act) variably apply to graduate students. Even when disability accommodations *are* explicitly outlined, eligibility for such accommodations for psychopathology-related disabilities (which could allow many to remain in training) may not be clearly communicated. Fears of negative reprisals may also impede trainees' ability to request clarifying information about whether they might qualify for accommodations, and how such accommodations might help them. One survey of college faculty indicated that the majority (70%) had little to no familiarity with campus accommodations for mental health (Price et al., 2017).

Many of these challenges persist among psychology faculty, including limited treatment options beyond one's professional network and varied access to appropriate accommodations. Opaque descriptions of disability-related leave policies may pose unique challenges to faculty, given that many job-related responsibilities are not amenable to being "paused" during leaves of absence (e.g., mentorship of students, grant-funded research with fixed timelines, teaching semester-long courses). More broadly, normalization of stress and distress in academia may exert unintended consequences for faculty with psychopathology. Although efforts to normalize feelings of overwhelm and work-related anxiety are intended to validate common difficulties experienced by academics, they might also be experienced as invalidating or pejorative to faculty members living with psychopathology that extends beyond so-called "normative" levels of stress or overwork (e.g., a psychopathology-related disability that requires accommodations).

5. Disclosure of Psychopathology
One common challenge in navigating professional spheres while living with psychopathology is negotiating the issue of disclosure—including whether, when, how, and to whom to disclose one's lived experience(s). Disclosure choice-points may start as early as undergraduate training, and they must be made repeatedly, in different contexts, with different recipients, considering varied costs and benefits to disclosure over time. Although a thorough review of the literature on disclosure of psychopathology is beyond the scope of this commentary (Corrigan & Matthews, 2009; Jones, 2011; Kerschbaum, 2017), we describe key elements that complicate disclosure decisions for psychology trainees and faculty.

First, disclosing psychopathology may be impeded by trainees' and psychologists' fears, founded or unfounded, of negative professional consequences, including loss of professional opportunities (e.g., due to negative judgments about people with psychopathology being unreliable or "difficult"). In some cases, such professional losses may result from well-intentioned behavior (i.e., directing opportunities elsewhere to "take things off the plate" of someone with psychopathology). In other cases, professional losses may result from unfounded scripts that are passed down across academic generations, simply because the sentiment that talking about one's mental health challenges is inappropriate, or unprofessional, has been propagated without challenge. Disclosure also risks more amorphous negative professional consequences, such as loss of respect from colleagues, especially if those colleagues hold negative implicit or explicit views toward psychopathology and/or intersection of research and lived experience.

Disclosure may have additional practical implications. For instance, many state licensure applications contain questions about psychopathology that likely violate protections for people with disabilities (Boyd et al., 2016). This likely functions to deter some psychologists from disclosing their experiences prior to licensure. For psychology faculty who conduct research in high-risk populations, or who provide clinical services, public disclosure may have negative consequences for professional liability in the case of adverse outcomes for clients or research participants, such as one's experiences being considered in legal proceedings. Disclosure may also increase the risk of overt discrimination or victimization. For example, some may experience harassment, be demoted, or fired due to their psychopathology. It is also possible that disclosure can contribute to tokenization and/or increased expectations of so-called "invisible service" following disclosure. For instance, disclosure may lead to expectations to take on administrative responsibilities related to student and/or faculty well-being. Disclosure may also lead to increased demands for emotional labor from colleagues and trainees who perceive individuals who are "out" about their lived experience as being possible allies and/or support persons.

There are also, of course, non-professional (personal) reasons that individuals might choose not to disclose their experiences. For many, self-stigma hampers disclosure. Some people may unfavorably compare themselves to others who appear to be functioning more effectively ("upward" comparisons). This can contribute to negative self-views related to psychopathology and its influence on one's work. In contrast, others may compare themselves to people who appear to be having greater challenges ("downward" comparisons). This may prevent some people from disclosing their experiences, because they do not feel as if they have it "bad enough" in comparison to others, especially if they remain high functioning and are perceived as professionally successful.

Additionally, for many academic faculty, our personal and professional lives overlap significantly. Thus, disclosure in professional settings may have spillover effects that influence relationships with colleagues who are simultaneously family or friends, and personal disclosures may spill over into professional arenas. Finally, disclosures that occur in more public venues may also contribute to concerns about the impacts on loved ones both within and outside one's professional circles, especially if the disclosures involve experiences that have not previously been shared (such as trauma or abuse).

For individuals who choose to disclose, concerns may remain regarding the extent and nature of the disclosure. For instance, some may feel more comfortable disclosing past psychopathology, specific diagnoses, or less-stigmatized experiences, but less comfortable disclosing current psychopathology or more heavily stigmatized symptoms. People who disclose must also carefully balance the amount of information provided to ensure that the goal of the disclosure is met (e.g., obtaining accommodations) while also avoiding the perception of "too much information" that may contribute to negative judgments from others. It is critical to note that these negative consequences *do not actually need to occur* in order to hamper disclosure. Rather, *anticipated stigma* and/or expectations of negative consequences related to disclosure may dissuade people, even in scenarios where the most likely outcomes following disclosure would be neutral or positive. See Supplementary Tables 1-3 for examples of positive and negative responses to disclosure (provided by some of the commentary authors per their own experiences), and statements made that evince stigma and decrease odds of disclosure.

6. Recommendations and Next Steps

We acknowledge that the recommendations below are non-exhaustive, will vary in difficulty and feasibility, and will have a variety of short- and longer-term costs. We therefore encourage readers to view this as a preliminary set of recommendations, subject to change on the basis of further insights from individuals with perspectives other than those represented here and empirical evidence with respect to efficacy for achieving desired changes. In the future, these recommendations could be expanded by drawing on practices from other mental health fields with more demonstrated willingness to accept personal experiences of psychopathology and self-disclosure, such as substance abuse counseling and social work (Eddie et al., 2019; GlenMaye & Bolin, 2007; Todd et al., 2019).

Recommendation 1: Develop an infrastructure to gather data towards field-wide standards for promoting accessibility and inclusion related to diverse and intersectional lived psychopathology experiences.

It is important to acknowledge that the authors of this paper approach this issue from positions of relative power - primarily White, tenure-track or tenured faculty who have been able to "succeed despite" or "pass as not having" significant psychopathology at various points in their lives. Persons of color, individuals with intersecting marginalized identities, and many others whose experiences differ radically from our own have largely been excluded from the field and, as a result, are not yet represented in conversations regarding paths toward change. Input from a much larger and more diverse group of stakeholders is sorely needed. Major accrediting bodies, such as APA, CPA, APPIC, and PCSAS, have the infrastructure necessary to collect critically important data on the experience of people with psychopathology within our field. We encourage these groups to develop a task force or consortium focused on promoting and reducing stigma around mental health in academia. Such a group would be well-positioned to systematically investigate barriers to success for people with psychopathology in academic environments, facilitate implementation of policies and programs to remediate those barriers, and evaluate the success of these policies over time.

Recommendation 2: Improve transparency in contexts where people with lived experience of psychopathology may feel pressured to disclose (or not to disclose) their experiences.
For instance, applicants for graduate programs and faculty positions are routinely asked why and how they became interested in their area of study. This can be challenging for applicants with psychopathology to navigate, as it is unclear how a brief disclosure of personal experience might be viewed. Indeed, an often-cited 2006 paper in *Teaching of Psychology* identifies disclosing one's lived psychopathology experience as a "kiss of death" in graduate school applications (Appleby & Appleby, 2006)—and to this day, some graduate program recommendation forms request ratings of applicants' "emotional stability" using unvalidated scales (we hope most faculty would decry the utility of these practices today). To remedy these issues and reduce ambiguity, application instructions should note whether lived psychopathology experience is acceptable to include in a personal or research statement. This is also relevant to "diversity" statements, insofar as search committees should be explicit regarding which types of diversity they are considering, and which aspects of diverse experiences are encouraged or discouraged with respect to disclosure in the statement.

We further recommend that institutions transparently describe the availability of supports and accommodations for people living with psychopathology. In the United States and Canada, federal law defines a disability as any impairment, including mental or psychological impairments that hinder or impede a person's ability to work without accommodations on either an episodic or permanent basis. Thus, many psychology trainees and faculty would be eligible for accommodations related to their experiences of psychopathology, but they may not have the necessary information or support to make use of them. These individuals may be dissuaded from self-identifying as disabled due to stigma, as suggested by rates of self-identified disability among professional psychologists (~5%, American Psychological Association, 2020) relative to the proportion endorsing lived psychopathology experience in confidential research studies (82%, of which 48% had diagnosable mental health difficulties; Victor et al., in press). Thus, trainees and faculty should receive explicit written information from their department and university about the types of accommodations available for people with psychopathology and how to obtain them. This information can be provided during new student orientation, new faculty onboarding, and in official documentation, such as departmental and graduate program handbooks. Faculty could also include these resources on their websites, which prospective trainees often visit. These resources should also specify who will be informed of a trainee's or faculty's accommodation requests, what information will be provided to them, how accommodations will impact professional evaluations and promotion, and what choices an individual has to accept, decline, or petition for alternative accommodations once they have been sought.

At times, an accommodation may involve a temporary leave of absence. Procedures for leaves of absence related to psychopathology should be accessible and easy to understand. This includes information on the minimum and maximum leave duration, whether it is paid or unpaid, whether the leave will compromise health insurance coverage, and the process by which one can return from a leave. If certain types of treatment or accommodations will trigger specific consequences for those who access them, this information should be readily available. For example, some institutions have policies which require a mandatory leave of absence following inpatient psychiatric care. Although these policies are themselves problematic (see below), they should be made transparent if and when they exist.

Finally, for true accessibility and inclusion, policies and procedures are not enough. Mechanisms to ensure procedural compliance must also be established. Trainees and faculty should be informed of which office handles complaints regarding discrimination or inaccessibility on the basis of psychopathology experience, and how such complaints should be made. Any complaint process should also be transparent with respect to whether information provided is confidential, how the complaint is addressed, and whether the person making the complaint is protected from retaliation.

Recommendation 3: Reduce barriers to help-seeking among trainees and faculty living with psychopathology.
Faculty and trainees in many applied psychology settings experience unique barriers to treatment because of their many roles as care providers, supervisors, practicum students, interns, and

collaborators. Programs should provide lists, referrals, or mechanisms for setting-up appointments with qualified and affordable mental health providers that are unlikely to present dual-relationship conflicts with students or faculty. Because stigma is not the sole deterrent to help-seeking, advocating for benefits like health insurance coverage for graduate students and faculty is crucial. Further, clinical trainees should also be educated about how to handle situations in which a fellow graduate student or faculty member is observed attending treatment at a clinical placement.

Efforts must also be made to avoid unintended, and often undesired, consequences to mental health treatment. Obtaining treatment, regardless of its intensity or type, should not trigger the loss of rights and privileges to which a person would otherwise be entitled, such as requiring the person to take an involuntary leave of absence or mandatory reporting of personal health information to colleagues or superiors. Trainees and faculty who take a medical leave of absence should continue to be paid and to retain health insurance coverage. The costs of trainee salaries and insurance premiums should be borne by the university, rather than the individual faculty mentor, to avoid situations in which faculty are incentivized to push trainees away from taking a necessary leave of absence. Such leaves of absence should trigger automatic extensions to degree timelines (for trainees) and tenure and promotion timelines (for faculty).

Recommendation 4: Establish clear differentiation between assessment of professional impairment and unfounded judgments regarding lived experience of psychopathology as it relates to suitability for education or employment.
Disclosure of psychopathology is often treated as a "red flag" in graduate admissions (Salzer, 2021). This violates federal protections regarding educational and occupational selection on the basis of disability (e.g., the Americans with Disabilities Act). Further, this practice is rarely (if ever) explicitly noted in official graduate admissions materials. Thus, this gatekeeping mechanism uniquely disadvantages applicants who do not have access to coaching from more senior individuals who are familiar with unspoken and implicit cultural norms around disclosure in psychological science.

At the same time, experiences with psychopathology may, for some individuals and at particular times, be so impairing as to preclude professional practice as a psychologist. However, determination regarding professional suitability should only be made through careful assessment, using validated, transparent, and reliable methods, by individuals with sufficient training and knowledge of the individual's symptoms, professional responsibilities, and current functioning, in consultation with their healthcare provider(s). At present, the authors are not aware of *any* validated protocols for making professional suitability determinations for psychology trainees or professionals. Should such protocols be studied and developed in the future, we strongly recommend including professional psychologists with lived experience of psychopathology in each step of the process, to improve the odds of creating an equitable, acceptable, and valid assessment strategy.

Recommendation 5: Reduce barriers to disclosure of psychopathology, for those who may wish to disclose.
More than trying to change or influence personal decisions to disclose psychopathology, we recommend focusing efforts on improving *responses* to disclosures. Drawing on principles from psychological science, these efforts could focus on helping recipients of disclosures to identify their own emotional reactions; acknowledge the potential difficulty inherent in the disclosure for the individual disclosing; create non-judgmental and empathic responses; assess the goal of the disclosure; and work collaboratively with the person disclosing to identify next steps (Barth & Wessel, 2021; Victor et al., 2021). We also recommend leveraging lessons learned from extant contact-based and education-based college student anti-stigma interventions (e.g., Kosyluk et al., 2016).

Protections should also be implemented so that individuals who want to disclose their personal experiences, especially individuals who want to challenge or critique how their program or field of study responds to lived experience of psychopathology, are protected from both the experience and the fear of adverse consequences.

One way to build communities receptive to disclosure would be to follow the leadership of campus LGBTQ+ organizations, many of which have created "allyship" programs for interested faculty and students who wish to signal their support for members of the LGBTQ+ community. These programs typically involve some level of training and a visible indicator of one's "ally" status, which can then be displayed in one's workspace to signal their support and willingness to serve as a safe space to discuss issues relevant to the LGBTQ+ community. Such a program could be adapted to serve a similar function for people with psychopathology (although concerns about increased emotional labor and service expectations for participating faculty should also be noted).

Recommendation 6: Increase incentives for consideration of psychopathology in diversity, equity, and inclusion (DEI) efforts.

Many professional organizations, accrediting bodies, and doctoral programs now have public statements regarding their commitment to diversity, equity, and inclusion. These statements should also explicitly include lived experience of psychopathology as a fundamental element of these efforts. To encourage representation and recognition of psychopathology within broader DEI efforts, concrete incentives should be provided to those individuals who advocate for awareness and inclusion of people with psychopathology in the field, comparable to those recommended for other aspects of DEI efforts. These incentives or acknowledgements may help to counteract the reality that much current work in this domain is underrecognized in professional evaluations, in spite of their potentially heavy costs (such as additional mentoring responsibilities, requests for public-facing advocacy work, and emotional labor in navigating personal disclosures).

7. Conclusion

The lived experience of psychopathology, past and present, is a common yet underdiscussed and often stigmatized part of clinical and applied psychology fields. We hope this commentary catalyzes initial steps toward changing the professional climate encountered by psychology trainees and faculty with lived experience of psychopathology. We invite readers, especially individuals in relative positions of power, to identify feasible, concrete steps you can take to move these conversations forward in your lab, program, department, research area, and discipline. As with broader discussions in psychological science regarding diversity, equity, and inclusion, a single commentary, conversation, or policy change is not enough. Ongoing, dedicated, and self-reflective work is needed to ensure real, sustained, and meaningful cultural and practical change. We hope, and truly believe, that our field is up to this critical task.

Conflicts of interest

We have no conflicts of interest to disclose.

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Supplemental Table 1

Authors' Examples of Negative Disclosure Experiences

Example

After disclosing to a person in leadership as a way to advocate for myself and explain a gap in productivity, his response was, "are you sure this is the career for you?"

After requesting a stop-the-clock for mental health reasons, the disability office told me I just needed a mentor and told me to talk to a senior faculty member in another department. I did not need a mentor, I needed an accommodation.

I was given partial course release to undertake a non-required external service role. When I could not undertake the role due to the impact of my mental illness I was informed that I would still need to take on the role moving forward or pay back the prior course releases (>30k) until I could demonstrate, with evidence, that this was a "bona fide" reason. This resulted in not only having to seek medical documentation outside the university and internally through human services with a physician who was condescending in our interactions. Through this process, this resulted in disclosing parts of my lived experience in several contexts when I was unready and unprepared.

When tearfully disclosing that I sometimes struggle with depression, my primary mentor shrugged saying, "well you're still productive when you're depressed."

I publicly disclosed to a national news outlet that my brother died by suicide, and it was one reason why I was so passionate about studying depression and clinical psychology. Some people in my program approached me afterwards and said, "Why would you want everyone to know that?" Of course, they were making the point for why I think it is important for people to normalize talking about mental health experiences and suicide.

I have a friend who disclosed having a family member with psychopathy in their graduate school personal statement. They got into the program, but a year later during a lab meeting covering tips for applying to graduate school, their mentor used my friend's personal statement disclosure as an example of "what not to do" and proceeded to make fun of them in front of the rest of the lab saying the disclosure was "stupid" since "psychopathy is genetic."

I was socializing with several people on the evening prior to the first day of a conference. One individual (not directly affiliated with the conference but who knew many people in the field) proceeded to converse with several other individuals who happened to be within our proximity. Soon after, the group conversation expanded. The individual who initiated this now larger conversation began talking about my research, going on to say that I don't only do research but also used to self-injure. I found myself experiencing a blend of anxiety, anger, and shock. This same individual went on to say, "you don't believe me?" (in relation to my lived experience) and proceeded to grab my arm to show everyone scarring from self-injury. I was mortified, beyond words, and almost in tears. I somehow managed to collect myself after this unwanted and ultimately forced disclosure, leaving the entire conversation, to seek refuge in my hotel room.

Note. Examples have been de-identified and lightly edited for clarity.

Supplemental Table 2

Authors' Examples of Positive Disclosure Experiences

Example

As a graduate student, I once broke down crying while teaching a class of 35 students. I was having intrusive thoughts related to my trauma, and I couldn't function. I had to cancel class. The students were incredibly understanding. One even stayed after class to let me know that it "was okay to not be okay." I then had to inform the course instructor that I had to abruptly cancel class. I explained my life circumstances, and he told me to not worry about a thing. That support helped immensely.

I once was in the midst of a depressive episode, and I finally confided in my mentor that I needed to off some of my workload. They responded with support, and it meant the world.

After disclosing to a colleague, she said, "wow, look at everything you've accomplished over the past few years despite those struggles." That felt incredibly validating.

After disclosing to my graduate supervisor, including my concerns about whether I could pursue an academic career, he acknowledged how hard things were for me, while also identifying ways in which academia would suit me well, such as the ability for work to ebb and flow over time, and not having to hold to a strict 9-5 work schedule.

Being told by my students that a part of their choice to work with me was my openness and transparency about my own lived experience, as this modeled it was okay to not be okay sometimes.

Receiving my promotion letter and seeing a statement that applauded my advocacy work, including explicit mention of sharing my personal lived experience.

When disclosing that I suffer from Major Depression and Generalized Anxiety Disorder, my post-baccalaureate research mentor disclosed that they also struggled with Major Depression and that this had informed their understanding of psychopathology in their research. They offered that this could also be helpful for my understanding, given my goals. I found this validating and encouraging.

During graduate school I found myself in the midst of a severe depressive episode. After much trepidation I elected to share this with my PhD advisor as I was unable to manage the many demands on my plate (and I suspected he was concerned). He empathically and non-judgmentally responded, validating my experience. This resulted in a collaborative advocacy effort for me to withdraw from coursework, take a break from clinical work, and him making accommodations regarding my research. The support offered will not be forgotten.

Following the decision to publicly share my own lived experience, I have received and continue receiving emails (and even hand-written letters) from people across the globe I've never met who indicated feeling hopeful and inspired about their own lived experience or about their loved ones who could identify with what I shared.

I have had several colleagues respond to my disclosures with disclosures of their own lived experiences of various forms of psychopathology. Almost invariably, I find these exchanges to be

rewarding (often mutually rewarding) and helpful for reducing my own self-stigma.

Note. Examples have been de-identified and lightly edited for clarity.

Supplementary Table 3

Authors' Examples of Experiences that Demonstrate Stigma and Hinder Disclosure

Example
A senior faculty member, when talking in front of a research group about veterans with PTSD, said, "they're all alcoholics".
A senior faculty member told a story about a woman who had panic attacks and called her "crazy."
A clinical supervisor told me not to take on a client with a long history of anorexia on my caseload because "it'll be impossible to get anywhere with them."
A clinical supervisor at an externship site told me to wear more layers (to cover my body) "because you'll trigger the patients." I think/assume she said it as a joke; I don't know if she knew whether I was sick with an eating disorder or not, and I had not disclosed anything to her. The patients were teenagers with emotional problems, including some with eating difficulties.
A clinical faculty member teaching a course on cognitive behavioral therapy called patients with borderline personality disorder "a lost cause" in therapy.
A research supervisor, in response to receiving work emails from me at 3am a few days in a row, said "I want some of whatever you're on," implying that I was using substances.
The DCT of a different program, upon hearing about my research on suicide and non-suicidal self-injury (which is not focused on borderline personality disorder), told me, "I don't treat the borderlines, because I did once and she killed herself, so now I don't treat them anymore."
When reporting on the status of an ongoing project, I mis-remembered and misstated details about it and my mentor said, "you're smoking crack".
A senior clinical faculty member was asked about their views on accepting students who disclose a mental health experience among their family members. They responded, "a lot of psychopathology is genetic, and you don't know if you want to take the risk. Even if the applicant doesn't say they have a disorder, they probably do."
One time, I was advised not to include my lived experience in a personal statement. As a result, I ended up never talking about my personal experience to anyone in psychology, and I even told others to do the same.
I once heard of a colleague who was fired for disclosing that they had psychopathology.
During graduate admissions, hearing a senior faculty member say that someone briefly mentioning having lived experience in an essay was not having "good boundaries" and evidence of "poor judgment."
A senior faculty member in our department who struggled with mental health difficulties was frequently referred to as "crazy," and was ultimately strongly suggested to retire.

When discussing my research with other psychology faculty members, one made a comment to the effect of, "at least you're not one of them, referring to the population I study.

I told a colleague that a trainee had disclosed trauma and mental health struggles to me, and his response was that they had "overshared."

I have routinely heard faculty members describe disclosure of lived experience of mental illness in personal statements as a "red flag" for graduate admissions decisions. This statement typically is *not* made in reference to specific disclosures, but rather is treated as accepted conventional wisdom and, not infrequently, as an absolute.

Note. Examples have been de-identified and lightly edited for clarity.