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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. This commentary compliments these findings by leveraging the perspectives of the authors and signatories, who have personal lived experience of psychopathology, to improve professional inclusivity in these fields. By "coming out proud," the authors aim to foster discussion, research, and inclusion efforts as they relate to psychopathology experiences in 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.

Keywords

stigma, psychology, clinical psychology, mental illness, psychopathology

Psychopathology[1] is incredibly common at the population level, and national and global stressors (e.g., the 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 & Pescosolido, 2020; Pescosolido et al., 2019). Although psychologists routinely champion antistigma efforts and awareness campaigns (Corrigan, 2016; see examples in 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. (2022) 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

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improve conditions for psychology trainees and faculty with personal experience of psychopathology.

The commentary authors and signatories have agreed to the following positionality statement 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 toward psychopathology in our professional training and careers. We recognize the need for substantial change in the fields of applied psychology with respect to how lived experience is recognized and addressed. Finally, we believe that acknowledging lived experience of psychopathology in our professional community—specifically, among those working to understand and reduce it—is an integral component of efforts to improve diversity, equity, and inclusion in 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. These important 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 seeking help 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 article (Victor et al., 2022). Thus, we aim to decrease stigma within the field, catalyze overdue self-reflection, and show more junior trainees that success in academia is possible for people who currently live, or have lived, with psychopathology. Beyond encouraging discussion, we hope this commentary facilitates critical changes in the field's recognition and acceptance of lived experience among psychologists.

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 has (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 in our own professional community, we can begin to publicly normalize attitudes toward and conversations about mental health and illness.

Second, openly acknowledging our own positionality is critical for conducting rigorous science. This necessity is generally recognized among the social sciences and humanities (e.g., Bourke, 2014; England, 1994) and is increasingly acknowledged even in traditional STEM (science, technology, engineering, and mathematics) disciplines such as engineering (Secules et al., 2021). And yet, questions of positionality are often neglected and even overtly dismissed in 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.

Guiding Assumptions and Beliefs

To contextualize our reflections, experiences, and recommendations, and to facilitate 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 because of 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—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 affect 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, but 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, to 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 possible only 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, nonpsychiatric 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 nonexhaustive and will benefit from continued, collaborative, and inclusive consideration looking forward.

The Lived Experience of Psychopathology in 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 the shortages of providers of mental-health care 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 and postdoctoral training, as well as postbaccalaureate 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 be 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.

Training programs often lack policies designed to support trainees with psychopathology. This dearth of policies regarding 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 they 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., the 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 being overwhelmed 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).

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, to 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, 2003; Jones, 2011; Kerschbaum et al., 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., because of 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 may function to deter some psychologists from disclosing their experiences before 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 be fired because of 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, nonprofessional (personal) reasons that individuals might choose not to disclose their experiences. For many, self-stigma hampers disclosure. Some people may unfavorably compare themselves with 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 with 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" relative to others, especially if they remain "high functioning" and are perceived as professionally successful.

In addition, for many academic faculty, 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 they feel 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 sharing "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 to hamper disclosure. Rather, anticipated stigma and/or expectations of negative consequences related to disclosure may dissuade people, even in scenarios in which the most likely outcomes following disclosure would be neutral or positive. For examples of positive and negative responses to disclosure (provided by some of the commentary authors from their own experiences) and statements made that evince stigma and decrease odds of disclosure, see Tables S1 to S3 in the Supplemental Material available online.

Recommendations and Next Steps

We acknowledge that the recommendations below are nonexhaustive, 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 (a) further insights from individuals with perspectives other than those represented here and (b) 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).

Recommendations

Recommendation 1: Develop an infrastructure to gather data toward field-wide standards for promoting accessibility and inclusion related to diverse and intersectional lived psychopathology experiences. It is important to acknowledge that we 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 our 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 the American Psychological Association, the Canadian Psychological Association, the Association of Psychology Postdoctoral and Internship Centers, and the Psychological Clinical Science Accreditation System, have the infrastructure necessary to collect critically important data on the experience of people with psychopathology in 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 in which 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 article 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, national laws define a disability as any impairment, including mental or psychological impairments, that hinders or impedes 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 because of stigma, as suggested by rates of self-identified disability among professional psychologists (~5%; American Psychological Association, 2020) relative to the percentage endorsing lived psychopathology experience in confidential research studies (82%, of which 48% had diagnosed mental-health difficulties; Victor et al., 2022). 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 student orientation, onboarding of new faculty, 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 accommodation requests from trainees or faculty; what information will be provided to them; how accommodations will affect 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 that 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 seeking help 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 seeking help, advocating for benefits such as 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, 2022). 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 be, for some individuals and at particular times, so impairing as to preclude professional practice as a psychologist. However, determination regarding professional suitability should be made only (a) through careful assessment, using validated, transparent, and reliable methods, (b) by individuals with sufficient training and knowledge of the individual's symptoms, professional responsibilities, and current functioning, and (c) in consultation with their health-care provider(s). At present, we 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. Based on principles from psychological science, these efforts could (a) focus on helping recipients of disclosures to identify their own emotional reactions, (b) acknowledge the potential difficulty inherent in the disclosure for the individual disclosing, (c) create nonjudgmental and empathic responses, (d) assess the goal of the disclosure, and (e) include collaboration with the person disclosing to identify next steps (Barth & Wessel, 2022; Victor et al., 2021). We also recommend leveraging lessons learned from extant contact-based and education-based college student antistigma 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 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 diversity, equity, and inclusion (DEI) efforts, such organizations and programs should provide concrete incentives to those individuals who advocate for awareness and inclusion of people with psychopathology in the field, and these incentives should comparable to those recommended for other aspects of DEI efforts. These incentives or acknowledgments may help to counteract the reality that much current work in this domain is underrecognized in professional evaluations, despite its potentially heavy costs (such as additional mentoring responsibilities, requests for public-facing advocacy work, and emotional labor in navigating personal disclosures).

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 they can take to move these conversations forward in their labs, programs, departments, research areas, and disciplines. As with broader discussions in psychological science regarding DEI, 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.

Transparency

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Author Contributions

S. E. Victor and J. L. Schleider conceptualized this commentary and wrote the initial manuscript draft. B. A. Ammerman, D. E. Bradford, A. R. Devendorf, J. Gruber, L. A. Gunaydin, L. S. Hallion, E. A. Kaufman, S. P. Lewis, and D. L. Stage contributed equally and are listed in alphabetical order. All of the authors contributed to manuscript revisions.

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At the time the manuscript was drafted, the majority of the authors were tenured faculty (S. P. Lewis, J. Gruber) or tenure-track faculty (S. E. Victor, J. L. Schleider, L. S. Hallion, B. A. Ammerman, D. E. Bradford, E. A. Kaufman) in accredited clinical psychology doctoral programs. The remaining authors were a tenure-track faculty member in neuroscience/psychiatry (L. A. Gunaydin) and graduate students in psychology (A. R. Devendorf) and social work (D. L. Stage). All of us have past and/or current personal lived experience of psychopathology. Many of us also have close family members who have experienced psychopathology, and we have been touched and inspired to write this commentary by our own experiences and those of our family members.

Notes

1. A variety of terms have been used to indicate mental health difficulties, including mental illness, mental disorder, and psychiatric diagnoses. In this article, 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) in the United States or Canada. Specific information for the authors is provided in the acknowledgments. The complete list of signatories is available online at https://www.sarahevictor.com/pops-commentary-signatories

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