

Stigmatizing Our Own: Self-Relevant Research (Me-Search) Is Common but Frowned Upon in Clinical Psychological Science

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Andrew R. Devendorf¹, Sarah E. Victor², Jonathan Rottenberg¹,
Rose Miller¹, Stephen P. Lewis³, Jennifer J. Muehlenkamp⁴, and
Dese'Rae L. Stage⁵

¹Department of Psychology, University of South Florida; ²Department of Psychological Sciences, Texas Tech University; ³Department of Psychology, University of Guelph; ⁴Department of Psychology, University of Wisconsin–Eau Claire; and ⁵School of Social Work, Temple University

Abstract

How often do clinical psychologists have a lived experience with, or close connection, to their research? Does the field of psychology accept this “me-search”? We undertook the first investigation of self-relevant research (aka “me-search”) and attitudes toward self-relevant researchers in a representative North American sample ($N = 1,776$) of faculty, graduate students, and other individuals affiliated with doctoral programs in clinical, counseling, and school psychology. More than 50% of participants had conducted self-relevant research, and those from minoritized backgrounds were more likely to conduct self-relevant research. When judging experimentally manipulated vignettes, participants who had not engaged in self-relevant research made more stigmatizing judgments of self-relevant research and self-relevant research disclosure than did those who engaged in self-relevant research. Psychologists and trainees had more negative attitudes toward self-relevant research on mental health topics (suicide, depression, schizophrenia) than physical health topics (cancer). We discuss how prejudice toward self-relevant research and mental illness negatively impacts ongoing diversity and inclusion efforts from within clinical psychological science.

Keywords

psychopathology, lived experience, prosumer, me-search, diversity

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Is it advisable for psychologists to conduct personally relevant research? In recent years, several renowned psychologists have disclosed that they conduct *self-relevant research*, which is research conducted by individuals who have a lived experience with, or close connection to, their research area (Devendorf, 2022).

In 2011, Marsha Linehan publicly shared that she used her personal experiences with mental health treatment to fuel the development of dialectical behavior therapy, which is now a well-validated, empirically supported therapy for the treatment of borderline personality disorder (Kliem et al., 2010; Linehan, 2020). Linehan waited decades to disclose her experience out of concern that colleagues would label her work as biased,

selfish, and untrustworthy (Linehan, 2020)—fears that are still felt by other self-relevant researchers today (Devendorf, 2020; Gardner et al., 2017; Victor, Lewis, & Muehlenkamp, 2022). In his memoir, *Another Kind of Madness*, Stephen Hinshaw (2017) recounted his own experiences with depression, obsessive thinking, and troubled eating patterns, as well as his family's experiences in facing mental health stigma. Hinshaw has stated that his experiences influence his motivation to

Corresponding Author:

Andrew R. Devendorf, Department of Psychology, University of South Florida
Florida

Email: andrewdevendorf@gmail.com

research and reduce stigma. In his book, *Why People Die by Suicide*, Thomas Joiner (2005) disclosed that he lost his father to suicide, an event that shaped Joiner's life and informs his devotion to understanding suicidal behavior. Although these disclosures by leading figures in mental illness research are compelling, they also underscore the lack of systematic data regarding the prevalence of self-relevant research and how it is regarded by other members in the field.

In this article, we first review the value of studying self-relevant research and then document the results of a study investigating the prevalence of self-relevant research in a North American sample of faculty, graduate students, and other individuals affiliated with clinical, counseling, and school psychology doctoral programs. These data afford comparisons of how psychologists view self-relevant research as a function of the research topic (e.g., suicide, schizophrenia, depression, and cancer) relative to non-self-relevant research and whether (and where) psychologists believe that disclosure of one's personal ties to their research is appropriate. We conclude by exploring whether self-relevant researchers are more or less accepting of other self-relevant researchers relative to those who have not engaged in self-relevant research.

Meta-Comment on Terms: Me-Search Versus Self-Relevant Research

In this article, we employ the term “self-relevant research” to describe our subject rather than the more commonly used term “me-search.” Although these terms have similar definitions, several commentators have noted that “me-search” is often used in a derogatory manner, as it is tied to labels that a researcher is biased, selfish, or trying to advance an agenda in their research pursuit (Gardner et al., 2017; Rios & Roth, 2020). In our experiences, we have observed—and regrettably participated in—conversations in which academics used “me-search” as a derogatory label for other people, which may include conjectures about a researchers' history with mental illness (e.g., overhearing audience members at a conference try to guess whether a substance use researcher has previously struggled with a substance use disorder; Devendorf, 2020). We have seen these conversations go unchallenged and without consideration for the potentially real consequences brought on by the labels—both the label of being a “me-searcher” and the label of a stigmatized identity such as a substance use disorder.

“Self-relevant research” was proposed as a more descriptive and neutral alternative to “me-search” in order to reduce the potential for these negative repercussions (Devendorf, 2022). In the current investigation, we assessed the value of this term in a survey of clinical

psychologists and trainees ($N = 1,742$). When asked how they felt about the term “me-search,” 68% of participants disliked the term, 20% found it neutral, and just 12% liked it. By contrast, when asked about “self-relevant research,” 19% of participants disliked the term, 48% found it neutral, and 33% liked it. Our results showed that “self-relevant research” was much preferred to “me-search,” and we advocate for the use of self-relevant research moving forward.

Why Studying Self-Relevant Research Is Important

A formal study of self-relevant research can benefit the field of clinical psychological science in several ways. Understanding how common self-relevant research is and who engages in it would provide better insight into who pursues and sustains a career in clinical, counseling, and school psychology—competitive fields that require one to undertake several roles (e.g., clinician, teacher, researcher) and put professionals at risk for burnout (Morse et al., 2012; Simpson et al., 2019). It is possible that people who conduct self-relevant research have unique assets (e.g., perspectives, experiences) that enhance their research enterprise. From this perspective, identifying and recruiting self-relevant researchers may be one method of bringing attention to understudied, though worthwhile, topics (e.g., research on lesbian, gay, bisexual, transgender, and queer [LGBTQ] topics), which may be more likely pursued by researchers with lived experiences in those areas. For example, recognizing stakeholders—such as Linehan, Hinshaw, and Joiner—who might be inclined to identify, empathize with, and advocate for, underrepresented groups can promote diverse perspectives on important but understudied research topics (Jones et al., 2021). Lastly, better understanding perceptions of self-relevant research among those in the field would facilitate efforts to improve acceptance and mentorship of people who engage in self-relevant research (Victor, Schleider, et al., 2022). In these respects, studying self-relevant research provides an important window into the profession's values, interests, and identities (including lived experience of mental illness; Jones et al., 2021; Neblett, 2019).

What Stereotypes Are Associated With Self-Relevant Research?

It is difficult to ascertain how clinical, counseling, and school psychologists perceive self-relevant research in the absence of formal studies. What we can infer is limited to circumstantial evidence drawn from commentaries (e.g., Gardner et al., 2017), advice guides (e.g., Devendorf, 2022), and survey research (e.g.,

Appleby & Appleby, 2006), all of which may be outdated and lacking representation of the field's self-relevant research views. These sources do not provide conclusive answers about how the field views self-relevant research, but they provide clues that psychologists and trainees have conflicting attitudes about self-relevant research and its disclosure.

On the surface, the pursuit of self-relevant research appears to be largely disfavored and stigmatized by scientists (for a commentary, see Gardner et al., 2017). Stigma occurs when people express prejudice (e.g., agreement with negative stereotypes) and support for, or engagement in, discrimination toward stigmatized groups (Rüsch et al., 2005). Scholars have noted that prejudice toward self-relevant research may manifest as agreement with stereotypes that self-relevant research is biased, partial, and selfish (Appleby & Appleby, 2006; Gardner et al., 2017; Sumerau, 2016). These stereotypes, if adopted, may lead scientists to question the credibility, trustworthiness, and authority of their colleagues who conduct self-relevant research (Altenmüller et al., 2021; Rios & Roth, 2020), which may result in adverse professional repercussions (e.g., rejection from graduate school, job, promotion) and even workplace bullying (J. I. Harris et al., 2022). In clinical psychology, widely used graduate application resources advise applicants to avoid disclosing personal connections to mental health difficulties (see Devendorf, 2022, for a review), as applicants may be viewed as “unstable” and “unable to function” (e.g., Indiana University-Purdue University Indianapolis, 2019, p. 4). Supporting this warning, a recent review concluded that disclosing one's mental illness on graduate applications may diminish one's chances of getting admitted—even for strong applicants—across mental health professions (Salzer, 2022). A survey of 457 psychology graduate programs identified self-relevant research as one such “kiss of death” in the admissions process to justify why applicants are rejected (Appleby & Appleby, 2006).

Similar risks of discrimination may exist for faculty who disclose self-relevant research. Prior to sharing that she lives with bipolar disorder, Kay Redfield Jamison (1996) was afraid that colleagues would view her in terms of her illness and not as a successful psychologist who studies bipolar disorder. Another example is Elyn Saks, a prominent self-relevant researcher with lived experience of schizophrenia. In her memoir, *The Center Cannot Hold: My Journey Through Madness*, Saks (2007) described the cautions she received before disclosing that she lives with schizophrenia:

Saks surveyed friends and colleagues for years before publishing [her book] and got very mixed advice . . . Academic colleagues warned her that coming out with

a disorder as serious as schizophrenia could only harm her. “You want to be known as the schizophrenic with a job?” one said. (Carey, 2011b, para 7)

As circumstantial evidence of these risks, it is worth noting that all the referenced self-relevant researchers publicly shared their lived experiences after having established credibility and job security (e.g., tenure) within their field. Despite reported fears among self-relevant researchers of these adverse consequences (Byrne et al., 2022; Carey, 2011a, 2011b), no study has formally examined whether self-relevant research is, in fact, viewed more negatively than non-self-relevant research among psychological scientists.

Although guidance regarding disclosure highlights negative perceptions of self-relevant research (Prinstein et al., 2013), there are mental health professionals and stakeholders who hold positive perceptions of it. Several authors of commentaries and studies acknowledge the unique perspectives offered by mental health professionals with lived experience, also known as *prosumers* (Boyd et al., 2016; Devendorf, 2020; Kundra & Salzer, 2019; Oberleitner et al., 2021; Victor, Lewis, & Muehlenkamp, 2022). For example, people with lived experience and mental health advocates may view self-relevant researchers as having greater insight or possessing intrinsic motivation. The following quote by Linehan captures this perspective: “I was in hell. And I made a vow: when I get out, I'm going to come back and get others out of here” (Carey, 2011a, para 28). When researchers such as Linehan disclosed their relation to their area of research, their psychology colleagues praised them as brave and courageous, identifying them as commendable role models. To provide more robust evidence about attitudes toward self-relevant research, we investigated whether self-relevant research is viewed more positively or negatively compared with non-self-relevant research.

Disclosure of Self-Relevant Research

Disclosure of one's motivations for academic research is a personal decision with benefits and consequences (Victor, Lewis, & Muehlenkamp, 2022), which are often contingent on the reactions of colleagues, stakeholders, and the lay public. However, how the disclosure of self-relevant research is viewed may also depend heavily on the research topic and, more specifically, how favorable or unfavorable perceptions of the research topic are.

In two recent experiments, Altenmüller et al. (2021) compared laypersons' attitudes about self-relevant research on veganism and LGBTQ topics with findings

suggesting that participants' own preexisting attitudes toward the research topic substantially moderate the effects of self-relevant research. Specifically, participants who held favorable attitudes toward the research topic viewed self-relevant researchers as more trustworthy and credible, and this pattern was reversed when participants held unfavorable attitudes about a research topic. This study suggests that a personal connection to one's research may amplify laypersons' positive or negative views toward the work, depending on the laypersons' views of the topic itself. In the current investigation, we examined how disclosure attitudes vary as a function of research topic among psychology trainees and professionals; specifically, we examined the research topics of suicide, schizophrenia, depression, and cancer.

The Current Study

In this study, we set out four aims to launch a novel research program on self-relevant research in a representative sample of North American faculty and graduate students in clinical, counseling, and school psychology fields. First, we documented the prevalence of self-relevant research in these fields and saw how they varied as a function of identity (e.g., race, gender, sexuality, history of mental health difficulties) and professional characteristics (e.g., career status, school training model).

Second, we examined whether psychologists and trainees viewed self-relevant research differently from non-self-relevant research. We developed a series of five vignettes to investigate this aim. Vignettes are an effective means of assessing stigmatizing attitudes without directly asking participants about socially undesirable beliefs (Link et al., 2004). Four vignettes described a self-relevant researcher of different topics (e.g., suicide, schizophrenia, depression, and cancer), and one vignette described a non-self-relevant researcher who studies coping skills for mental health. We opted to use these three mental health difficulties because they capture a spectrum of mental health experiences, which may vary in eliciting stigmatizing reactions (Link & Phelan, 2013). We also chose the topic of cancer as a proxy for self-relevant research on physical health topics (see Aim 3 below). Although we hypothesized that self-relevant research would be associated with higher levels of stigma and be viewed as more inappropriate to disclose than non-self-relevant research, we also hypothesized that self-relevant research would be viewed as having more positive attributes (e.g., "A researcher is admirable") compared with non-self-relevant research.

Third, we compared psychologist and trainee attitudes about self-relevant research as a function of

research topic. On the one hand, it might be expected that psychologists would hold more accepting views about self-relevant research on mental health topics. On the other, stereotypes about mental illness are more likely to attack the mental fitness of a person, which may be used to discredit one's research ability on clinical topics (Teachman et al., 2006). We hypothesized that psychologists would stigmatize self-relevant research on mental health topics more than self-relevant research physical health topics (i.e., cancer); in turn, self-relevant researchers who study physical health topics would be perceived as having more positive attributes than those who study mental health topics.

Lastly, we explored whether psychologist and trainee attitudes about self-relevant research varied as a function of whether participants themselves pursued self-relevant research. We did not have directional hypotheses for this exploratory aim given the paucity of literature specific to this question. On the basis of prior work and theory, we felt that results could plausibly fit one of two patterns. In one case, self-relevant researchers might view other self-relevant researchers more positively, perhaps by the process of cognitive dissonance (i.e., having conducted self-relevant research would lead one to accept others who conduct self-relevant research). This would be consistent with findings of other research suggesting higher reported acceptability of stigmatized behaviors by individuals who have themselves engaged in these behaviors, such as that predicted by the drug-normalization framework (e.g., Kolar et al., 2018). However, we also anticipated that self-relevant researchers might be more aware of negative stereotypes associated with self-relevant research and may project those stereotypes onto other self-relevant researchers; this would be consistent with theories of internalized mental illness stigma in which discrimination experiences are associated with endorsement of stereotypes related to one's mental illness (e.g., Lysaker et al., 2012). Our aims and hypotheses were preregistered on OSF at <https://doi.org/10.17605/OSF.IO/BCSU3>, and materials for this study have been made publicly available at <https://osf.io/qw8rv/>.

Method

Study methodology overview

Detailed recruitment and procedures for this study were previously reported (for details, see Victor, Devendorf, et al., 2022). We report how we determined our sample size, all data exclusions, all manipulations, and all measures in the study. All procedures were approved by, and conducted in accordance with, the second author/co-principal investigator's institutional review board.

Our procedure involved extracting email addresses for faculty, directors of clinical training, graduate students, and postdoctoral trainees affiliated with accredited American and Canadian doctoral training programs in clinical, counseling, and school psychology, as well as for training directors at accredited doctoral internship programs in the United States and Canada. To facilitate representative sampling, we obtained a comprehensive list of accredited doctoral programs from the following organizations' publicly available directories during the second half of 2020: American Psychological Association (APA), Canadian Psychological Association, and Psychological Clinical Science Accreditation System. After visiting websites for each program, a trained research assistant followed a standardized protocol to extract publicly available email addresses. Concurrently, a comprehensive list of member doctoral internships was obtained from the Association of Psychology Postdoctoral and Internship Centers (APPIC) internship directory. Because internship websites provided far less accessible contact information than departmental websites, we limited contacts for internship programs to the training directors whose emails were listed in the APPIC directory. Training was conducted by the second author/co-principal investigator, and a subset of data was double-entered by a graduate student to ensure accuracy.

A recruitment email was sent to all valid email addresses on January 24, 2021, and a reminder email was sent on February 1, 2021 (total delivered emails = 8,952). With respect to doctoral training programs ($n = 433$), emails were sent to 432 Director of Clinical Trainings (DCTs) (the remaining DCT was a coinvestigator), 4,791 faculty, 2,949 students, and 100 postdoctoral trainees. With respect to doctoral internships, emails were available for all but two programs ($n = 680$), most of which were APA accredited ($n = 642$). Emails were sent by the second author/co-principal investigator, unless there was a potential conflict of interest (e.g., emails sent to people in their current program); in these cases, another team member sent emails to these recipients. To reduce sampling bias, we described the study as focusing on "research and clinical interests," making no mention of self-relevant research or mental health difficulties. The survey remained open until March 1, 2021. Participants could enter a drawing for one of several \$50 Amazon gift cards.

A total of 2,045 individuals consented to participate (22.8% of emails distributed). Of these, 42 responses were removed as ineligible because the respondent was pursuing a bachelor's degree ($n = 3$), involved in a nonaccredited program ($n = 9$), or marked program accreditation as "not relevant" ($n = 30$). An additional

44 responses were removed because no items were completed beyond consent, leaving an analytic sample of 1,959 responses before data cleaning.

Survey instrument

Most survey items were developed specifically for this project in consultation with the entire team and prior literature reviews. The survey was distributed via Qualtrics and took 15 to 30 min on average to complete. Beyond the consent form, participants could skip any item. The survey had three broad aims: (a) characterize prevalence and characteristics of mental health difficulties among psychology faculty and trainees, (b) characterize prevalence and characteristics of self-relevant research, and (c) examine perceptions of the acceptability and disclosure of self-relevant research. Aim 1 is reported elsewhere (see Victor, Devendorf, et al., 2022). This study focuses on Aims 2 and 3. We describe items relevant only to this study.

Self-relevant research vignettes. Following completion of consent and demographics items, but prior to questions regarding self-relevant research engagement and mental health experiences, each participant was randomly assigned to one of five vignettes. Five conditions were used to balance concerns about obtaining adequate cells sizes in each condition while collecting a rich set of data. The vignettes were modeled after those used in prior studies of mental illness stigma (Link et al., 2004; Wood et al., 2014).

Each vignette described a researcher with a gender-neutral name ("Sam") who conducts research on one of the following topics: suicide, schizophrenia, depression, cancer, or coping skills for mental health. The vignette depicted why Sam was interested in pursuing their research. In the suicide, schizophrenia, depression, and cancer conditions, Sam was depicted as having a "lived experience" with one of these conditions and that "Sam feels a personal investment in their research given their lived experience." Below is an example from the schizophrenia condition (for other conditions, see <https://osf.io/vtxa2/>):

Sam conducts research on schizophrenia. Sam first became interested in schizophrenia research after being diagnosed with schizophrenia. With schizophrenia, Sam experiences auditory hallucinations, delusions, and blunted emotional expression. As a result, Sam feels a personal investment in their research given their lived experience with schizophrenia. Ultimately, Sam hopes to make a difference with their research.

We also included a non-self-relevant research condition, in which Sam conducts research on “coping skills for mental health.” This topic has several benefits as a non-self-relevant research comparison: (a) The subject matter remains clinical and thus allows a more direct comparison with the four other vignettes; (b) the topic and motivation to research coping skills is common in clinical psychology, which increases the external validity of this vignette for a sample of psychologists; and (c) the vague language of “mental health coping skills” was strategized to be broadly relevant to the sample without endorsing a specific mental health intervention. The vignette in this condition read as follows:

Sam conducts research on coping skills for mental health. Sam first became interested in coping skills research after an Introductory Psychology Course. As a result, Sam feels passionate about their research. Ultimately, Sam hopes to make a difference with their research.

After each vignette, we used two items as a manipulation/attention check. The first item asked, “What is Sam’s research area?” and the second item asked, “Why did Sam get interested in their research topic?” Participants had to pass both manipulation checks to be included in data analysis on the attitudinal items (see below).

Stigma, strengths, and disclosure scale for self-relevant research. After viewing a vignette, participants were asked follow-up questions about Sam’s research pursuit on the stigma, strengths, and disclosure (SSD) scale, developed for the purposes of this study. The SSD scale covered both stigmatizing attitudes and strengths-based attitudes. Items were selected on the basis of literature reviews (e.g., Appleby & Appleby, 2006; see Devendorf, 2020, for a review) and consultation with the research team. Stigmatizing attitudes included items that described Sam as “biased,” “selfish,” “irresponsible,” and “has bad judgment” and the belief that “Sam should pursue a different topic.” Strengths-based attitudes included items that Sam “has motivation,” “is admirable,” “has insight,” “should be accepted,” and “serves as a good role model for the academic community.” Participants were asked the degree to which they agreed with each statement on a 5-point Likert scale (*agree strongly* to *disagree strongly*).

Participants were also provided with different contexts and asked the degree to which it would be appropriate for Sam to disclose their “personal interest in their research topic” in each context. Contexts included “in a personal statement”; “when giving a talk at a

research conference”; “to anyone in the academic community”; “publicly, such as when writing an essay for a magazine, blog, or talking with a journalist”; and “when giving a job talk or at a job interview.” Items were rated on a 5-point Likert scale (*very appropriate* to *very inappropriate*).

Self-relevant research status. After the vignettes and attitudinal items, participants were asked about whether they have ever engaged in self-relevant research. The following definition was provided:

“Self-relevant research” refers to the pursuit of research by someone with lived experience with, or a personal connection to, their research area. A personal connection could be, for example, a family member or a close friend who has lived experience with their research area.

Participants could select one of three choices: “Yes, I currently conduct this type of research”; “Yes, not currently but in the past”; or “No.” For participants who endorsed either “yes” response, several follow-up questions were presented, including the extent to which their self-relevant research connects to their identity (e.g., personal lived experience, connection to their topic through another person, other, or any combination of the above), the timing of their self-relevant research (e.g., having a personal connection before and/or after pursuing a research topic), and whether their self-relevant research includes mental health difficulties or related topics (for wording, see <https://osf.io/qw8rv/>).

Mental health difficulties. Participants were asked to respond to two yes/no items assessing lifetime experience of mental health diagnoses and lifetime mental health difficulties. The first question asked, “Have you ever been diagnosed with a mental health condition by a professional?” The second question asked, “Have you ever experienced mental health difficulties?” The terminology used for this second question was intentionally broad because some mental health difficulties are not labeled as specific conditions, and not all respondents may have had access to a mental health provider who could make a formal diagnosis.

Demographic and professional information. All participants were asked about their age, gender, race, sexual orientation, highest education obtained, professional status, and current institution’s training model (e.g., clinical scientist, scientist-practitioner).

Data analysis

Data analysis was conducted in the Statistical Package for the Social Sciences (SPSS) Version 27 (IBM Corp, 2020). Missing data were examined and found to be low (range: 0%–5.3%), with the self-relevant research status variable demonstrating the highest percentage of missingness (5.3%). We proceeded with listwise deletion given the low amounts of missingness and the large remaining sample (Schlomer et al., 2010).

We used descriptive and crosstab statistics to report the prevalence of self-relevant research. Group comparisons of self-relevant research were conducted (sample size permitting) on the basis of the following characteristics: gender, race/ethnicity, sexual orientation, professional status, history of mental health difficulties, and doctoral program accreditation. These categories reflect those that had cell sizes greater than five for examining prevalence of self-relevant research across categories. Group comparisons of categorical variables were conducted using χ^2 tests, whereas group comparisons with dimensional variables were conducted using independent-samples t tests.

For the SSD scale items, we ascertained that all were normally distributed and omitted participants who missed either one of the two attention checks ($n = 16$). We also verified that randomization successfully occurred across the vignettes on the basis of age, race, gender, sexual orientation, professional status, and self-relevant researcher status; no differences were observed across conditions on these variables ($ps > .05$).

To provide preliminary psychometric evidence of our SSD scale, we examined the factor structure of the items on each vignette with exploratory factor analysis (EFA); we also conducted the EFA on the full remaining sample while collapsing across vignettes ($n = 1,786$). We used a promax (oblique) rotation because it was likely that the identified attitude factors would be correlated (Watkins, 2018). Factors were extracted with visual inspection of the scree plot and considering eigenvalue values exceeding 1.0 (Coolican, 2009). Parallel analysis and minimum average partials were also examined (Horn, 1965; O'Connor, 2000; Velicer, 1976). Following our preregistered plan, we considered retention of factors and items by inspecting significant ($p < .05$) pattern coefficients ($\geq .30$), using theory to guide interpretation (Bandalos & Gerstner, 2016). The internal consistency of each factor was examined using Cronbach's α . Normality for each factor was assessed with skewness and kurtosis. Multivariate outliers ($n = 8$) were identified and omitted based on Mahalanobis distance, with a cutoff of $\chi^2 df = 3$, $\alpha < .001$ (Cohen et al., 2003).

Once the factor structure of the SSD scale was established, each factor was used as an outcome in a series

of one-way analysis of variance (ANOVA) models, in which we examined the independent effects of self-relevant research status (self-relevant research vs. non-self-relevant research) and research topic (mental illness topic vs. physical illness topic) on attitudes about the hypothetical researcher. For the research topic analyses, we ran analyses in which we collapsed the mental illness vignettes and then examined the unique effects of each research topic (i.e., suicide, schizophrenia, depression). We also conducted a two-way ANOVA to explore the effect of vignette type (self-relevant research vs. non-self-relevant research) and participant status (has conducted self-relevant research vs. has not conducted self-relevant research) on attitudes. We performed two-tailed tests with an α set to .05 across analyses. It should be noted that sample size was dependent on the number of individuals willing to complete the survey and was not based on a priori power analyses.

Effect sizes were interpreted using Cohen's d for one-way ANOVAs and η_p^2 for the two-way ANOVA (Norouzian & Plonsky, 2018). Cohen's d indicates the standardized difference between two means. In between-subject designs, Cohen's d can be interpreted as a percentage of the standard deviation; specifically, a Cohen's d of 0.5 means the difference equals half a standard deviation (Lakens, 2013). The η_p^2 statistic measures the proportion of variance in an outcome that is associated with membership of the grouping variable. An η_p^2 of .10 means that 10% of the total variance can be accounted for by group membership, although caution is warranted when comparing this value between studies (Lakens, 2013). We followed empirically derived benchmarks to guide interpretation of effect sizes. For Cohen's d , values of 0.15, 0.36, and 0.65 were considered small, medium, and large effects, respectively. For η_p^2 , values of .006, .031, and .095 were considered small, medium, and large effects, respectively (Lovakov & Agadullina, 2021).¹ It is crucial to note that small effect sizes may still be important but must be interpreted within the context of this study's variables. For example, small effect sizes are common in experimental research that examines prejudice, where they can have meaningful consequences on outcomes such as discrimination (Funder & Ozer, 2019; Lovakov & Agadullina, 2021).

Results

Aim 1a: How common is self-relevant research among psychologists and trainees?

More than one third (33.9%) of respondents reported currently conducting self-relevant research. Slightly more

Table 1. Demographic Characteristics of the Sample by History of Conducting Self-Relevant Research ($N = 1,694$)

Characteristic	Self-relevant researchers (n)	Non-self-relevant researchers (n)	Full sample (N)
Gender			
Cisgender woman	713 (77.2%)	605 (78.8%)	1,393 (78.1%)
Cisgender man	184 (19.9%)	156 (20.3%)	358 (20.1%)
Nonbinary/gender nonconforming	18 (2.0%)	6 (78.8%)	24 (1.3%)
Other	5 (0.5%)	0 (0%)	5 (0.3%)
Transgender man	2 (0.2%)	1 (0.1%)	3 (0.2%)
Transgender woman	1 (0.1%)	0 (0%)	1 (0.1%)
Race/ethnicity			
Non-Hispanic White	756 (81.7%)	658 (85.6%)	1,490 (83.3%)
Hispanic/Latinx	84 (9.1%)	43 (5.6%)	135 (7.6%)
Multiracial/biracial/other	18 (1.9%)	5 (0.7%)	23 (1.3%)
Asian/Asian-American/Canadian	77 (8.3%)	58 (7.5%)	141 (7.9%)
Black/African-American/Canadian	55 (5.9%)	29 (3.8%)	87 (4.9%)
Middle Eastern/North African	22 (2.4%)	12 (1.6%)	35 (2.0%)
Native American/First Nations/Alaskan Native	15 (1.6%)	10 (1.3%)	28 (1.6%)
Hawaiian/Pacific Islander	3 (0.3%)	1 (0.1%)	4 (0.2%)
Sexual orientation			
Heterosexual/straight	665 (72.6%)	658 (86.5%)	1,394 (78.8%)
Bisexual	118 (12.9%)	55 (7.2%)	183 (10.3%)
Homosexual/gay/lesbian	67 (7.3%)	26 (3.4%)	98 (5.5%)
Pansexual	30 (3.3%)	12 (1.6%)	42 (2.4%)
Other	31 (3.4%)	7 (0.9%)	43 (2.4%)
Asexual	5 (0.5%)	3 (0.4%)	8 (0.5%)

than a fifth (20.7%) reported conducting self-relevant research in the past. Overall, more than half of participants (54.6%) reported having conducted self-relevant research at some point in the past. For brevity, we will refer to these participants as self-relevant researchers. Table 1 provides descriptive characteristics of self-relevant researchers.

Among self-relevant researchers ($n = 905$), more than half (52.4%, $n = 474$) of this subsample have pursued self-relevant research on mental health problems when asked about the research topic, meaning that more than a quarter (27.9%) of the full sample has conducted self-relevant research on mental health difficulties. Likewise, 54.3% said that they have conducted self-relevant research on other topics (participants could indicate neither, one, or both of these types of self-relevant research). Most self-relevant researchers (81.4%) had a connection to their field of study before starting work in that field, whereas just 19.9% started a research pursuit before developing a personal connection. Of the self-relevant researchers who have ever studied mental health difficulties ($n = 474$), 71.9% have personal lived experience with mental health difficulties, and 66.7% have a close connection to someone with the mental health difficulties they study (participants could indicate

neither, one, or both of these aspects of self-relevance). Of the self-relevant researchers who study other topics, 78.3% have a personal lived experience with their given topic, and 42.5% have a close connection to someone else with experiences related to their topic of study.

In summary, among clinical, counseling, and school psychologists and trainees, more than half had engaged in self-relevant research, and more than one quarter had engaged in self-relevant research on mental health topics. Further, most of them had a connection to their topic prior to engaging in its study, and their connection to the topic is driven by their own lived experiences.

Aim 1b: Who conducts self-relevant research among psychologists and trainees?

Rates of conducting self-relevant research were similar across graduate students (57.2%), postdoctoral fellows (57.7%), and faculty (55.2%), whereas significantly lower rates of self-relevant research were reported among clinicians (34.1%) affiliated with doctoral programs, $\chi^2(4, N = 1,708) = 25.65, p < .001$. Interestingly, graduate students had higher rates (39.7%) of currently conducting self-relevant research compared with postdoctoral fellows (28.8%), faculty (32.0%), and clinicians

(2.3%), $\chi^2(8, N = 1,708) = 86.21, p < .001$. Experience with self-relevant research overall did not significantly differ across training-program model: clinical science (56.7%), science practitioner (55.7%), and practitioner scholar (52.3%), $\chi^2(3, N = 1,628) = 1.30, p = .73$. However, clinical science programs (41.2%) had higher rates of current self-relevant researchers relative to scientist-practitioner (35.8%) and practitioner-scholar (21.6%) programs, $\chi^2(6, N = 1,628) = 34.34, p < .001$. See the Supplemental Material available online for a table displaying the professional characteristics of self-relevant researchers.

Rates of self-relevant research did not differ between psychologists and trainees who identified as cisgender men (54.1%) and cisgender women (54.3%), $\chi^2(1, N = 1,672) = 0.004, p = .95$. Although rates of self-relevant research were also high (79%) among nonbinary participants, transgender participants, and participants reporting “other” for gender, statistical comparisons were not conducted because of small sample size ($n = 33$). However, self-relevant research did vary by sexual orientation, $\chi^2(1, N = 1,691) = 48.70, p < .001$; psychologists and trainees identifying as a sexual orientation other than heterosexual (71.0%) were significantly more likely to report conducting self-relevant research than heterosexual/straight participants (50.4%). Self-relevant research was also more common among psychologists and trainees from minoritized racial/ethnic backgrounds (63.3%) compared with non-Hispanic White participants (52.2%), $\chi^2(1, N = 1,703) = 15.36, p < .001$.

Further, psychologists and trainees with a history of mental health difficulties (59.1%) were more likely to have conducted self-relevant research at some point compared with people who had no history of mental health difficulties (35.1%), $\chi^2(1, N = 1,684) = 57.28, p < .001$. Rates of current self-relevant research were also higher among psychologists and trainees with a history of mental health difficulties (37.8%) compared with people without mental health difficulties (18.7%), $\chi^2(2, N = 1,684) = 60.32, p < .001$. Overall, these findings suggest that clinical, counseling, and school psychologists and trainees with marginalized backgrounds, experiences, or identities may have a higher prevalence of conducting or having conducted self-relevant research.

Aim 2: Do psychologists and trainees discredit self-relevant research more than non-self-relevant research?

Prior to running our main analyses, we conducted factor analysis to assess the psychometric evidence for our SSD attitude scales. An EFA on the SSD items yielded three factors across the five vignettes (Tables 2 and 3), consistent with our expected three-factor structure.²

Factor 1 represents *stigmatizing (negative) attitudes* about self-relevant research, capturing perceptions that self-relevant research is associated with “bias,” “selfishness,” “lack of responsibility,” “bad judgment” and that the self-relevant researcher “should pursue a different topic.” Factor 2 represents *strengths-based (positive) attitudes* about self-relevant research, including perceptions that someone who conducts self-relevant research is “admirable,” “insightful,” “motivated,” “serves as a good role model,” and “should be accepted by the academic community.” Factor 3 represents *disclosure views* about self-relevant research, namely, the degree to which it is appropriate to disclose one’s connection to research in a certain context (e.g., personal statement, job talk, research conference, public platform, to anyone in academia).

Each SSD subscale demonstrated acceptable to good levels of internal consistency across the five vignettes—stigmatizing attitudes: $\alpha_s = .77-.83$, strengths-based attitudes: $\alpha_s = .67-.78$, and disclosure views: $\alpha_s = .80-.91$. Higher scores on the stigmatizing attitudes (Factor 1) and disclosure views (Factor 3) scales indicate more negative attitudes. Higher scores on the strengths-based attitudes (Factor 2) scale indicate more positive attitudes. Table S2 in the Supplemental Material presents means and standard deviations across vignettes. All subscales correlated with one another across vignettes—Factors 1 and 2: $r_s = -.54$ to $-.71$, Factors 1 and 3: $r_s = .22$ to $.35$, and Factors 2 and 3: $r_s = -.17$ to $-.34$. See the Supplemental Material for details.

To investigate attitudes about self-relevant research, we ran a series of one-way ANOVAs to examine the effect of self-relevant research (self-relevant research vs. non-self-relevant research) on the stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales. Psychologists and trainees endorsed more stigmatizing attitudes for hypothetical self-relevant researchers ($M = 2.13, SD = 0.60$) than for a hypothetical non-self-relevant researcher ($M = 1.91, SD = 0.54$), $F(1, 1774) = 40.18, p < .001$, with a small to medium effect size ($d = 0.38$, 95% confidence interval [CI] = [0.26, 0.49]). In other words, psychologists rated hypothetical self-relevant researchers as more biased, selfish, and prone to bad judgments than a hypothetical non-self-relevant researcher.

Psychologists and trainees also disapproved of disclosing self-relevant research ($M = 2.68, SD = 0.71$) across contexts more than non-self-relevant research ($M = 2.14, SD = 0.74$), $F(1, 1774) = 162.83, p < .001$, with a large effect size ($d = 0.76$, 95% CI = [0.64, 0.88]); this means that psychologists and trainees viewed disclosure of self-relevant research (i.e., disclosing one’s reason for interest in a research area) as more inappropriate in contexts such as a personal statement, job talk, and/or research conference.

Table 2. Pattern Coefficients and Reliability of the Stigma, Strengths, and Disclosure Scale Using Promax Rotation With Kaiser Normalization

Item	Factor 1: stigmatizing attitudes					Factor 2: strengths-based attitudes					Factor 3: disclosure views							
	Suicide	Schiz	Depress	Cancer	Coping	Full	Suicide	Schiz	Depress	Cancer	Coping	Full	Suicide	Schiz	Depress	Cancer	Coping	Full
1. Biased	.553	.602	.531	.452	.483	.613	.046	.147	.092	.154	.091	.252	.029	.041	.087	.011	.014	.073
2. Selfish	.508	.477	.607	.454	.692	.547	-.149	-.154	-.070	-.194	-.037	-.137	-.047	-.128	-.035	-.085	-.016	-.082
3. Irresponsible	.790	.755	.835	.861	.787	.803	-.013	.098	.035	-.021	.048	.018	.009	.053	-.050	-.093	-.055	-.034
4. Should pursue different topic	.749	.762	.637	.647	.598	.662	-.068	.016	-.041	.005	.001	-.072	-.016	.049	.093	.147	-.014	.026
5. Bad judgment	.895	.845	.813	.754	.701	.798	.063	.000	-.034	-.039	-.043	-.043	-.012	-.096	-.021	.028	.049	-.036
6. Admirable	-.215	-.080	.021	-.012	.004	-.127	.491	.640	.627	.692	.508	.525	.013	-.004	-.037	.008	-.070	-.072
7. Insight	.070	.108	.006	.131	.050	.177	.803	.742	.672	.640	.583	.805	.006	.008	.056	-.033	.071	.049
8. Motivation	-.090	.079	.072	.024	-.096	.088	.420	.375	.521	.682	.462	.604	-.020	-.018	-.001	.117	-.035	.023
9. Should be accepted	-.307	-.458	-.260	-.039	-.312	-.275	.496	.276	.493	.539	.254	.440	-.003	-.061	.041	-.116	-.068	-.044
10. Good role model	-.411	-.239	-.063	-.032	.062	-.203	.319	.555	.623	.594	.742	.510	-.046	-.030	-.019	-.046	.035	-.059
11. Disclose in personal statement	.117	-.057	.020	.016	-.011	.027	.139	-.032	.042	.020	-.024	.050	.721	.639	.666	.668	.793	.724
12. Disclose at research talk	-.081	-.074	.032	-.006	-.043	-.077	-.075	-.005	.089	.046	.040	-.013	.713	.781	.785	.793	.910	.822
13. Disclose at job talk/interview	.124	.095	.046	.024	-.063	.071	.218	.143	.135	.062	-.021	.160	.819	.773	.776	.759	.856	.813
14. Disclose publicly	-.080	.002	-.089	-.039	.103	-.053	-.276	-.142	-.273	-.106	.003	-.199	.573	.630	.528	.691	.711	.660
15. Disclose to anyone in academia	-.146	.032	-.003	.014	.023	.001	-.223	-.028	-.220	-.049	.014	-.051	.546	.695	.498	.718	.813	.710
Cronbach's α	.834	.798	.812	.766	.770	.801	.778	.750	.754	.752	.667	.754	.814	.830	.798	.848	.908	.860

Note: For each factor, coefficients are shown for each of the five vignettes (suicide, schizophrenia [schiz], depression [depress], cancer, and coping skills [coping]) as well as for the full sample results. Boldface indicates the items extracted for each factor; Cronbach's α shows the internal reliability of the boldfaced items for each factor. The extraction method was principal axis factoring.

Table 3. Eigenvalues and Variance Explained for Rotated Factor Solutions of the Stigma, Strengths, and Disclosure Scale Using Promax Rotation With Kaiser Normalization

Factor and statistic	Vignette					
	Suicide	Schizophrenia	Depression	Cancer	Coping skills	Full sample
Factor 1: stigmatizing attitudes						
Eigenvalue	5.31	4.86	4.97	1.34	2.83	2.63
Variance explained	35.38%	32.57%	33.15%	8.93%	18.89%	17.50%
Factor 2: strengths-based attitudes						
Eigenvalue	1.18	1.16	1.31	2.58	1.40	1.48
Variance explained	7.89%	7.71%	8.73%	17.19%	9.35%	9.86%
Factor 3: disclosure views						
Eigenvalue	2.29	2.56	2.11	4.61	4.42	4.76
Variance explained	15.27%	17.03%	14.09%	30.74%	29.50%	31.72%
Total variance explained	58.45%	57.30%	55.96%	56.86%	57.74%	59.08%

Conversely, psychologists and trainees rated a hypothetical self-relevant researcher ($M = 3.99$, $SD = 0.50$) more highly on the strengths-based attitudes subscale than a hypothetical non-self-relevant researcher ($M = 3.63$, $SD = 0.42$), $F(1, 1774) = 154.80$, $p < .001$, with a large effect size ($d = 0.74$, 95% CI = [0.64, 0.88]), meaning that self-relevant researchers were regarded as more admirable, motivated, and insightful. In sum, hypothetical self-relevant researchers were stigmatized at higher levels, but these researchers were viewed as having more positive attributes compared with a non-self-relevant researcher.

Aim 3a: Do psychologists and trainees stigmatize self-relevant research on mental health topics more than physical health topics?

A series of one-way ANOVAs compared the effect of self-relevant research on mental health topics (i.e., collapsing vignettes on suicide, schizophrenia, depression, $n = 1,070$) with the effect of self-relevant research on physical health topics (i.e., cancer, $n = 352$) on each SSD subscale. All ANOVAs had significant omnibus F tests, $ps < .001$. On the stigmatizing attitudes subscale, psychologists and trainees stigmatized a hypothetical self-relevant researcher on mental health topics ($M = 2.17$, $SD = 0.61$) more than a hypothetical self-relevant researcher on physical health topics ($M = 2.02$, $SD = 0.54$), with small to medium effects ($d = 0.24$, 95% CI = [0.12, 0.36]). On the disclosure views subscale, psychologists and trainees viewed disclosure

of self-relevant research on mental health topics ($M = 2.79$, $SD = 0.69$) more negatively than disclosure of self-relevant research on physical health topics ($M = 2.33$, $SD = 0.64$), $p < .001$, with medium to large effects ($d = 0.68$, 95% CI = [0.56, 0.81]). Lastly, psychologists and trainees endorsed positive attitudes on the strengths-based attitudes subscale for a hypothetical self-relevant researcher on physical health topics ($M = 4.07$, $SD = 0.46$) more than a hypothetical self-relevant researcher on mental health topics ($M = 3.96$, $SD = 0.51$), with small effects ($d = 0.23$, 95% CI = [0.10, 0.35]).

Aim 3b: Are certain self-relevant research topics more stigmatized than other self-relevant research topics?

Although we found evidence that psychologists and trainees generally viewed self-relevant research on mental health topics more negatively than self-relevant research on physical health topics, we also wondered how attitudes varied by specific self-relevant research topic. A series of one-way ANOVAs examined the effect of self-relevant research topic (e.g., suicide, schizophrenia, depression, cancer) on each SSD subscale (Table 4). The omnibus F tests were all significant, $ps < .001$ (for details, see <https://osf.io/qw8rv/>), with small to large effect sizes of vignette type on each subscale—stigmatizing attitudes: $d = 0.25$, 95% CI = [0.13, 0.37], strengths-based attitudes: $d = 0.22$, 95% CI = [0.11, 0.35], disclosure views: $d = 0.69$, 95% CI = [0.57, 0.82]. We conducted Games-Howell post hoc tests to examine mean differences across vignettes because Levene's test

Table 4. Means and Standard Deviations for Each Factor and Vignette ($N = 1,776$)

Vignette	Stigmatizing attitudes (M)	Strengths-based attitudes (M)	Disclosure views (M)	Cell size (n)
Self-relevant research on suicide	2.27 (0.65)	3.95 (0.52)	2.94 (0.70)	352
Self-relevant research on schizophrenia	2.18 (0.60)	3.96 (0.51)	2.65 (0.67)	358
Self-relevant research on depression	2.06 (0.57)	3.96 (0.51)	2.80 (0.68)	360
Self-relevant research on cancer	2.02 (0.54)	4.07 (0.46)	2.33 (0.64)	352
Non-self-relevant research on coping skills	1.91 (0.54)	3.63 (0.42)	2.14 (0.74)	354

Note: Standard deviations are given in parentheses.

suggested violations of homogeneity of variance for each ANOVA.

Psychologists and trainees stigmatized a hypothetical self-relevant researcher on suicide ($M = 2.27$, $SD = 0.65$) significantly more than hypothetical self-relevant researchers on depression ($M = 2.06$, $SD = 0.57$, $p < .001$) and cancer ($M = 2.02$, $SD = 0.54$, $p < .001$). Psychologists and trainees also stigmatized a hypothetical self-relevant researcher on schizophrenia ($M = 2.18$, $SD = 0.60$) significantly more than hypothetical self-relevant researchers on depression ($p = .023$) and cancer ($p = .001$). However, participants did not stigmatize a hypothetical self-relevant researcher on depression significantly more than a hypothetical self-relevant researcher on cancer ($p = .843$). Thus, although psychologists and trainees generally held the most negative attitudes toward mental health topics, such as self-relevant research on suicide and self-relevant research on schizophrenia, psychologists and trainees did not differ in stigmatizing attitudes for self-relevant research on depression versus self-relevant research on cancer, suggesting that stigma toward self-relevant research also varies by research topic.

Paralleling findings on the stigmatizing attitudes scale, psychologists and trainees viewed disclosure of self-relevant research on suicide ($M = 2.94$, $SD = 0.70$) more negatively than disclosure of all other topics, including self-relevant research on schizophrenia ($M = 2.65$, $SD = 0.67$, $p < .001$), depression ($M = 2.80$, $SD = 0.68$, $p = .027$), and cancer ($M = 2.33$, $SD = 0.64$, $p < .001$). Similarly, self-relevant research on schizophrenia was perceived more negatively to disclose than self-relevant research on cancer ($p < .001$). Finally, although psychologists and trainees viewed self-relevant research on depression less negatively than self-relevant research on schizophrenia on the stigmatizing attitudes scale, and with no differences to self-relevant research on cancer research (see above), psychologists and trainees viewed disclosure of self-relevant research on depression more negatively than self-relevant research on schizophrenia ($p = .017$) and cancer ($p < .001$).

Psychologists and trainees also endorsed more positive attitudes (i.e., on strengths-based attitudes) for a hypothetical self-relevant researcher on cancer ($M = 4.07$, $SD = 0.46$) than for a self-relevant researcher on suicide ($M = 3.95$, $SD = 0.52$, $p = .009$), schizophrenia ($M = 3.96$, $SD = 0.51$, $p = .017$), and depression ($M = 3.96$, $SD = 0.51$, $p = .011$). No significant differences of self-relevant research across mental health topics were observed for strengths-based attitudes ($ps > .05$). Overall, self-relevant research on mental health topics was more stigmatized, appraised with fewer positive attributes, and viewed as more inappropriate to disclose than physical health topics.

Aim 4 (exploratory): Do self-relevant researchers discredit other self-relevant researchers?

A two-way ANOVA examined the effect of vignette type (self-relevant research vs. non-self-relevant research) and the participants' experience (has conducted self-relevant research vs. has not conducted self-relevant research) on stigmatizing attitudes, strengths-based attitudes, and disclosure views. First, there was an interaction between vignette type and self-relevant research experience on the stigmatizing attitudes subscale, $F(3, 1679) = 18.00$, $p < .001$, $\eta^2 = .011$. Although self-relevant researchers ($M = 1.91$, $SD = 0.54$) and non-self-relevant researchers ($M = 1.88$, $SD = 0.55$) did not differ on stigmatizing attitudes for the non-self-relevant research coping skills vignette, self-relevant researchers ($M = 2.00$, $SD = 0.55$) were less likely to stigmatize a hypothetical self-relevant researcher than non-self-relevant researchers ($M = 2.28$, $SD = 0.62$), $\eta^2 = .007$.

There was also an interaction with a small effect size between vignette type and self-relevant research experience on strengths-based attitudes, $F(3, 1679) = 7.38$, $p = .007$, $\eta^2 = .004$. Although there were no group differences on strengths perceptions of the non-self-relevant research vignette (self-relevant researchers: $M = 3.63$, $SD = 0.43$; non-self-relevant researchers: $M = 3.62$, $SD = 0.43$), the

self-relevant research vignettes were viewed more positively by participants who have conducted self-relevant research ($M = 4.07$, $SD = 0.49$) compared with people who have never conducted self-relevant research ($M = 3.90$, $SD = 0.49$), $\eta^2 = .006$. There was no interaction between vignette type and self-relevant research experience on disclosure views, $F(3, 1679) = 1.93$, $p = .165$, $\eta^2 = .001$. Thus, self-relevant researchers held fewer stigmatizing attitudes about self-relevant research than people who had never conducted self-relevant research, and self-relevant researchers viewed other self-relevant researchers as having more positive attributes.

Discussion

This preregistered study documented the prevalence of self-relevant research in clinical, counseling, and school psychology doctoral programs and compared psychologists' and trainees' attitudes about the pursuit of self-relevant research with non-self-relevant research. In a large sample drawn from accredited doctoral programs, more than half of psychology trainees and faculty had conducted self-relevant research, and more than one in four participants had conducted self-relevant research on mental illness topics. These data suggest that self-relevant research is common across clinical, counseling, and school psychology training environments.

Our study revealed that attitudes about self-relevant research were nuanced and depended on whether a participant had previously conducted self-relevant research. Non-self-relevant researchers were more likely to judge a hypothetical self-relevant researcher as more biased, selfish, and having bad judgment relative to a non-self-relevant researcher, whereas self-relevant researchers were more likely to rate other self-relevant researchers as more admirable, motivated, and insightful relative to a non-self-relevant researcher. Disclosure of self-relevant research (i.e., confiding a personal connection to one's research) was viewed as more inappropriate than disclosure of non-self-relevant research (i.e., disclosing a nonpersonal reason for pursuing research) across participants. In other words, views about disclosure did not differ on the basis of personal engagement in self-relevant research.

Some caveats to these findings should be noted. Although these results validate concerns that disclosing a personal connection to one's research is viewed negatively in comparison with non-self-relevant research (Carey, 2011b; J. L. Harris, 2021; Linehan, 2020), the averages on the stigmatizing attitudes subscale were below the midpoint across self-relevant research vignettes, indicating that overall attitudes were not disapproving of self-relevant research. This response

pattern is typical for research on stigma and prejudice (Campbell & Brauer, 2021; Wood et al., 2014).

It appears, then, that self-relevant researchers face a somewhat precarious situation—they may be more admired or castigated depending on the context, which accords with indications that some perspectives discourage self-relevant research disclosure (e.g., Prinstein, 2022) and others encourage it (Devendorf, 2020; Salzer, 2022; Victor, Lewis, & Muehlenkamp, 2022). This suggests that there are risks and rewards for sharing a personal connection to one's research topic, which can conceivably have longstanding payoffs or ramifications to one's career. Consider the case of diversity statements. It is now commonplace for universities and funding bodies to request that an applicant discuss how they incorporate or contribute to elements of diversity, yet it is sometimes unclear to applicants how to respond to these prompts or what level of personal detail to use (Kang et al., 2016). We suspect that self-relevant research disclosure varies by context, domain of research, and other aspects of one's identity and position within the field (Rüsch & Kösters, 2021; Salzer, 2022), but future research should clarify these relationships.

Our study did find evidence that acceptance of self-relevant research depends on the research topic. We confess that it was discouraging to find support for our hypotheses that psychologists stigmatize self-relevant research on mental health difficulties, such as suicide, depression, or schizophrenia, to a greater extent than physical health conditions, such as cancer. This is especially disheartening when 50% and 27% of the same sample also endorsed a personal history of depression and suicidal ideation, respectively (Victor, Devendorf, et al., 2022). Our findings indicate that the pursuit of self-relevant research on suicide and schizophrenia is more stigmatized than self-relevant research on depression and cancer, and disclosure of all mental health topics was viewed as more inappropriate than disclosure of self-relevant research on cancer. It is possible that these findings are at least partially explained by population prejudice toward mental illness relative to physical illness (Link & Phelan, 2013; Teachman et al., 2006).

That these data provide evidence of prejudice toward mental illness—from those within mental health fields—suggests the need for a reckoning. As mental health professionals, psychologists are gatekeepers for public discourse about mental illness. These data are cause for psychologists to engage in self-reflection about what it means to be leaders in mental health when we express or imply to professionals from within our own field, "Do not talk about your mental illness or risk facing the consequences." Surely a tension exists between psychologists' stated values and mission (APA, 2011)—to be effective mental health advocates—when

we ourselves hold negative judgments about mental illness. Our data speak to the need for intentional advocacy and antistigma efforts within our field to ensure greater acceptance, inclusion, and safety of people with lived experience of mental health difficulties. Direct efforts might include identifying and reducing structural obstacles that prevent people with lived experience from seeking help or disclosing their lived experience, while also increasing incentives for consideration of self-relevant research and psychopathology in diversity, equity, and inclusion efforts (for recommendations, see Victor, Schleider, et al., 2022).

Understanding characteristics of self-relevant researchers affiliated with doctoral training environments can illuminate who pursues and remains in a clinical science career. We found that 81% of self-relevant researchers had a connection to their field before starting work in that field, which suggests that lived experience, or personal connections to a topic, may be among the reasons why people pursue domains of psychology research. Self-relevant researchers were also more likely to hold marginalized identities, including being more likely to be members of minoritized sexual orientation and/or racial/ethnic groups, and to have a higher prevalence of mental health difficulties or diagnoses.

Faculty and students had similar rates of ever conducting self-relevant research, but graduate students were more likely to be conducting self-relevant research when they completed the survey. Our data cannot definitively explain this faculty and student discrepancy, but we propose some possible explanations. First, personal experience may draw people into psychology research, but whether they continue to pursue self-relevant research is influenced by other factors. Perhaps research interests simply change over time or the opportunity to conduct self-relevant research wanes over time, as people who want to stay in a research career may have to shift their interests or research focus to obtain a job or grant (Allegrante, 2018; Oakley, 1999). A second possibility is that perceptions of self-relevant research have shifted over time, leading to cohort effects whereby current students are more likely to engage in self-relevant research relative to more established members of the field (Brown & Patterson, 2021; Shepherd et al., 2021). Another possibility is that self-relevant research is more stigmatized and less accepted in the academic community, which leads self-relevant researchers to be selected out of the field prior to engaging in research as faculty.

This study provides the first assessment of self-relevant research and attitudes in a large, representative data set of psychology faculty and trainees from accredited North American programs. The measurement of self-relevant research was optimized by having

participants respond to an operationalized definition of self-relevant research, and our vignette approach allowed us to experimentally compare attitudes about self-relevant research by self-relevant status and across several research topics. We developed the SSD scale for self-relevant research to assess a multitude of attitudes about self-relevant research and disclosure. The SSD scale demonstrated good preliminary psychometric properties and can be modified, improved, and tested in future research.

Our study's limitations should be noted. Although we aimed to capture a representative sample of psychologists and trainees affiliated with accredited doctoral programs and internships, some eligible individuals did not have publicly accessible contact information and thus may not have had the opportunity to participate. We attempted to reach these persons by asking study recipients to forward our email recruitment to other people within their program and expand our survey reach, but this process hampered our ability to determine a precise response rate. Although our response rate was similar to or greater than that of other studies with overlapping aims (Tay et al., 2018), and care was taken in study advertising to avoid oversampling of people who conduct self-relevant research, the relative proportion of eligible individuals who completed the survey is a limitation. Our study also targeted only accredited programs in school, clinical, and counseling psychology, so these findings may not apply to psychologists who do not engage in clinical practice (e.g., social, cognitive psychology).

The novelty of our study created some methodological challenges and limitations. Although we assessed a spectrum of attitudes and stereotypes by developing the SSD scale, we regret not incorporating specific items that capture perceived credibility and trustworthiness of self-relevant research for comparison with other published work (Altenmüller et al., 2021). The SSD scale captures attitudes only about self-relevant research rather than behaviors enacted toward individuals who engage in self-relevant research. We advise future researchers to develop behavioral approaches to assess and capture the possibility of more serious discriminatory actions taken toward self-relevant researchers (e.g., rejection from graduate school, a job, or scholarship). The experimental vignettes were also not counterbalanced by research topic and self-relevant research, which limited our ability to disentangle the unique effects of self-relevant research and unique effects of specific research topics (e.g., schizophrenia, depression) on attitudes toward the hypothetical researcher. Another notable limitation resulted from reliance on a vignette about cancer as a proxy for research on physical health topics. These decisions were made to balance

concerns about obtaining adequate sample size across conditions while ensuring a rich data set for this first investigation. Given that we found variability in attitudes toward self-relevant research on mental health topics, we hope future studies will explore how self-relevant research attitudes on physical health conditions varies by topic.

Implications for clinical psychological science

This study is an important first step toward understanding the prevalence of and climate surrounding self-relevant research. We hope these data will foster needed conversations about the status quo of accepting (or not) self-relevant research on mental illness topics. Our work should spark greater efforts to better understand how to cultivate inclusion—rather than exclusion—of self-relevant research in psychology. We highlight five takeaways from our findings and recommend areas to guide future investigation.

Disclosure of self-relevant research has risks and rewards. Although over half of psychologists and trainees have conducted self-relevant research, our data suggest that self-relevant researchers should weigh the risks when deciding to disclose a personal connection to a research topic. Self-relevant researchers who study mental illness topics such as suicide, schizophrenia, and depression may be especially likely to be viewed pejoratively by their colleagues. We suspect that it is no longer the case that any disclosure of mental illness is verboten but may depend on how the disclosure is contextualized. How and when a disclosure occurs may impact perceptions of severity, which may affect other people's perceptions about one's ability to function in graduate school, clinical work, and research. However, actual reactions to disclosures, regardless of contextualization, are likely to vary, and further research is needed to identify predictors of positive versus negative or mixed reactions to self-relevant research and/or mental illness disclosures.

Even if these prejudices are held by only a minority of psychologists and trainees, it should be considered that a few prejudiced individuals who hold high positions of power can be damaging (e.g., department chair vs. untenured professor in a psychology department). That said, disclosing one's personal connections to research can yield benefits, such as people viewing one's research pursuit as more admirable. Disclosing self-relevant research may also provide someone with a sense of empowerment and reduced burden, as secrecy can be a harmful coping strategy for those with concealable stigmatized identities (Chaudoir & Fisher, 2010). It is not within the scope of this article to recommend whether

to disclose, or how to disclose, one's identity, but we hope that future discussions will advance guidance and mentorship on effective disclosure, for example, through efforts such as the Honest, Open, and Proud Program (Kundert & Corrigan, 2022; Rüsç & Kösters, 2021).

Investigate and address the causes of stigma toward self-relevant research. One important focus for future work should be to investigate the causes of biases against self-relevant research. One possibility in clinical psychology is that stereotypes about self-relevant research manifest before students even enter graduate school, when students are warned that applicants are “often screened out” for disclosing their own psychopathology (Prinstein, 2022, p. 26). This wisdom—whether or not people agree with it—may be passed along across cohorts out of positive intentions to have students optimize their chances of admission to graduate school. That said, this wisdom originates at the program level and thus must be confronted and addressed at the structural and programmatic levels. Fears about disclosing lived experience of mental health difficulties (and other experiences) are unlikely to abate if fears of professional repercussions (e.g., workplace discrimination) and negative judgments continue to persist.

Accepting self-relevant researchers connects to diversity and inclusion efforts in psychological science. We found that members of minoritized backgrounds—including members of LGBTQ sexual orientations, non-White racial/ethnic groups, and individuals with a history of mental health difficulties—were more likely to conduct self-relevant research compared with the majority members. When considering that psychology has continued to struggle to gain adequate representation for individuals from these marginalized backgrounds in research (Callahan et al., 2018; Dimmick & Callahan, 2022; Miller & Orsillo, 2020), it becomes crucial that psychologists not also discriminate against someone for their personal motivations to pursue research. Along these lines, although this article has primarily discussed self-relevant research on mental illness, we hope our arguments are also considered in the context of self-relevant research on nonmental health topics and intersectionality (e.g., people with multiple disadvantaged identities), including scholars who use their experiences with their identities as motivation to pursue their respective topics (e.g., an African American/Black researcher studying health disparities among African American/Black samples; J. L. Harris, 2021). Future researchers might consider how anti-self-relevant research bias depends on both professional context and the self-relevant research identity. For example, how do attitudes about self-relevant research vary among medical, social work, and nursing professionals?

Are psychologists who pursue self-relevant research trusted more by the public?

The benefits and risks of conducting self-relevant research should be explored in other applied contexts, such as science communication. Expanding on preliminary work by Altenmüller et al. (2021), future investigations should examine whether self-relevant researchers yield any strengths when connecting with the public, such as self-relevant researchers on mental illness topics who might be able to destigmatize mental illness at a national stage. However, it is just as possible that self-relevant researchers on mental health topics would face more challenges, such as their science not being taken seriously (e.g., Rios & Roth, 2020).

What are the strengths and challenges to conducting self-relevant research, and how do self-relevant researchers navigate their path?

Our study speaks only about beliefs about self-relevant researchers, but a worthwhile direction is to investigate the experienced benefits and challenges encountered when conducting self-relevant research. One fruitful research question regards how to facilitate the end goal of helping self-relevant researchers explore the strengths and challenges of their lived experiences. Put otherwise, what are strategies that self-relevant researchers employ to engage with their lived experience as an asset while also managing any (potential) ongoing challenges associated with that lived experience? The quote below from Stephen Lewis, a self-relevant researcher on non-suicidal self-injury and an author of the present article, serves as one example of how we might understand how self-relevant researchers use their lived experience to their advantage:

I believe my suffering has led me to be more insightful in my work and understanding of who I am as a person. I feel compassion for people who are struggling as I once did, and I have cultivated this into a commitment to help them. This has helped to fuel my work. (Lewis, 2016, p. 1266)

Conclusion

Self-relevant research in psychology has historically been relegated to discussions of red flags, “kisses of death,” or gossip, without thoughtful consideration for the unintended consequences of these conversations (Devendorf, 2022). We have argued and documented evidence that real prejudice exists toward self-relevant research when compared with non-self-relevant research, which has strong repercussions not just for our field but also for individuals who conduct self-relevant research. We have shown that self-relevant

research is not uncommon or insubstantial in psychology; more than half of applied psychologists and trainees have conducted self-relevant research, and approximately one third actively conduct self-relevant research. This data substantiate the importance of including self-relevant research with diversity, equity, and inclusion efforts in applied psychology (Brannon et al., 2018; Haynes-Mendez & Nolan, 2021). That said, we acknowledge and are not arguing that self-relevant research is better or should be the norm in psychology. Rather, we believe that these data indicate that the field needs to have a deeper reckoning with self-relevant research and with the acceptability of self-relevant research and self-relevant researchers.

Transparency

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Author Contributions

Andrew R. Devendorf: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Writing – original draft; Writing – review & editing.

Sarah E. Victor: Conceptualization; Data curation; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Writing – review & editing.

Jonathan Rottenberg: Investigation; Project administration; Resources; Supervision; Writing – review & editing.

Rose Miller: Investigation; Writing – review & editing.

Stephen P. Lewis: Investigation; Writing – review & editing.

Jennifer J. Muehlenkamp: Investigation; Writing – review & editing.

Dese'Rae L. Stage: Investigation; Writing – review & editing.

Declaration of Conflicting Interests

Although we declare that there were no conflicts of interest with respect to the authorship or the publication of this article, we believe that the topic of this article warrants a positionality statement. We conduct mental health research and have either personal experiences or close connections to people with lived experience in this area. Several of us identify as people who conduct self-relevant research. Although we believe that many factors drive our motivation to study our given research interests, we believe that our personal connections to our research can be valuable in enriching our work. It is possible that these experiences make us more receptive to self-relevant research. Rather than conceal this background, we think it is scientifically useful to practice transparency of our perspectives.

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ORCID iDs

Andrew R. Devendorf  <https://orcid.org/0000-0002-0142-6359>

Sarah E. Victor  <https://orcid.org/0000-0002-7944-7299>

Jonathan Rottenberg  <https://orcid.org/0000-0001-6128-4359>

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Supplemental Material

Additional supporting information can be found at <http://journals.sagepub.com/doi/suppl/10.1177/21677026221141655>

Notes

1. These benchmarks were calculated by converting Lovakov and Agadullina's (2021) Cohen's d values of 0.15, 0.36, and 0.65 into η^2 values using Lakens's (2013) effect-size calculator (<https://osf.io/wgsi3/>).
2. When using parallel analysis, considering eigenvalues exceeding 1.0, and visually inspecting the scree plot, we found that a three-factor solution was supported. However, minimum average partials supported a two-factor solution. We proceeded with the three-factor solution because it was consistent with our theorized three-factor solution and because three of four methods (including our preregistered methods) provided support for this solution.

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