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ESSENTIAL SCIENCE CONVERSATIONS: ADDRESSING MENTAL HEALTH STIGMA IN CLINICAL PSYCHOLOGY (MARCH 15, 2024)

TRANSCRIPT

Shandol Hoover: Welcome. Thank you for joining us today. I'm Shandol Hoover, APA, Director of Science Special Projects and Implementation. This program is part of an APA series called Essential Science Conversations, where panelists and audience members can engage in an open dialogue about emerging topics and psychological science.

Before we get started with today's session, I want to share a few quick announcements. First, we hope you'll visit apa.org/science to learn how APA helps psych scientists on the hill, in the lab, and around the globe, and that you'll join over 50,000 other subscribers by subscribing to a free Science Spotlight newsletter to get firsthand insight into funding, news, events and resources and more, and that you'll subscribe to our free editor's choice newsletter for free articles delivered right to your inbox.

Second, thanks to many of those of you who submitted questions for today's program when you registered. You can ask a question as the program is taking place in real-time. There's a Q&A feature on the dashboard. Please enter all your questions there. We'll be monitoring those questions throughout the program. Finally, this program is being recorded, so once it ends, everyone who registered will receive an email with a link to the recording and a transcript in about two weeks. I'll now turn things over to Dr. Mitch Prinstein, Chief of Science.

Dr. Mitch Prinstein: Hi, everybody. Thank you so much for joining us today for this incredibly important conversation on a topic that we need to be talking more about, and that is the stigma that is occurring towards mental health, not only when we see that outside of our own graduate school and psychology settings, but also inside. I'm so grateful to the folks who are here today who have volunteered to talk about this subject and who have been real leaders nationally in helping to increase awareness, in fact, even suggesting this webinar. Love that our growing audience on these essential science conversations are thinking of such fantastic topics for us to discuss and are letting us know, and then we set them up. That's really exciting.

Today, we are excited to host this conversation about mental health stigma that occurs in the clinic, in the lab, in the classroom, and the community. Psychological scientists are not immune, and we look forward to engaging in this discussion about actionable strategies that we can take in order to address this stigma.

First, let me introduce these great panelists for today's discussion. Andrew Devendorf is a PhD candidate in clinical psychology at the University of South Florida, and he's currently completing his predoctoral internship at Seattle Puget Sound VA. Following the internship, Andrew will complete a health services research and development postdoc at the Seattle Puget Sound VA. Congrats on that, Andrew.

Dr. Omar Gudiño is the Deputy Clinical Director in the San Francisco Bay Area at the Child Mind Institute. Excited for you to be here, Omar. Maya Nauphal is a PhD candidate in clinical psychology at Boston University and a psych intern at Montefiore Medical Center, which is

affiliated with Albert Einstein College of Medicine. Thank you for taking time out of your internships to be doing this. I know how busy that year is.

Dr. Sarah Victor is a clinical psychologist and an assistant professor of psychological sciences at Texas Tech University. Last but certainly not least, Dr. Michaela Swee is a staff psychologist and the director of clinical training at McLean Hospital in the trauma continuum of clinical care, and also an instructor in psychology in the Department of Psychiatry at Harvard Medical School.

I wanted to start us off by welcoming you all, and again, thanking you for participating. Let's dive right in. What are some of the ways in which we see mental health stigma manifesting in the experiences of psychologists themselves, including psychologists who may have a history of mental health difficulties, but may feel that there's not a safe place for them to express that? When do we first see that occurring for folks who are answering to our fields, do you think? I'll just throw that out to anyone.

Dr. Sarah Victor: I think it starts often in our very first psychology classes. Talk about abnormal psychology, statistically speaking, psychopathology is actually not abnormal. A lot of the language that we see in our textbooks around these experiences can be stigmatizing, and that sets a precedent then as people move into research labs and move into applying to graduate school. I think it starts really early, personally.

Dr. Omar Gudiño: I would absolutely agree with that. I think there's this challenge where at the same time if you have these gigantic classes of abnormal psychology, or today they're being renamed, which I think is a good thing, you have this first introduction to mental health, you study these disorders as these are discrete things that exist and you do them chapter by chapter. We also know that when students are reading that for the first time, you've also self-identified with lots of those things.

At the same time that we're seeing lots of questions and concerns about whether these things are maybe what I've experienced, we also see this very different way of thinking about disorders, and that's all happening at the same time.

Maya Nauphal: I think inherent in that experience is this othering of individuals with mental health difficulties that happens. There's this assumption that we have, I think, as a field that folks who are in the field are not the folks who we are treating, that individuals with mental health difficulties cannot be psychologists and vice versa. I think that's untrue, and it's also unhelpful because it contributes to this idea that people with mental health difficulties are inherently different. It also contributes to the silencing of folks within the field who do struggle or who have struggled with their mental health.

You see this in a lot of ways. One of the ways you see this, speaking as more of a trainee when you're applying to study psychology, you're often given this feedback that, don't talk about your own experience. That's unprofessional. That's the- what's the phrase, Andrew, that you use a lot? - the kiss of death in applications. I think that's also something that we continue to see in our field.

Dr. Mitch Prinstein: The epidemiological data suggests that at least 50% of humans will experience significant psychopathology at some point in their lifetimes. The jig is up, folks. This is happening to one of every two people. For us to not talk about it or to make people feel that they can't express that as part of their inspiration for the work that they do or for wanting to enter into our field, it just feels incredibly silly. We know in fact that it is likely a big part of the experience

of why many people get into the field or how they are able to bring that lived experience into their research or their practice.

Andrew, so glad you were able to rejoin. Any thoughts you want to share on what's inspired you to do such great work in this area or ways in which you've seen stigma influence the ability of our field to do its job?

Andrew Devendorf: First, I want to do a quick sound check. You guys can hear me, right? Okay. Not sure what happened. Just dropped. Great question. I think this is a question I tend to try to answer both, again, scientifically but also my personal experiences. I grew up with family and personal connections to depression. I think just naturally based on those experiences, that made me inclined to be like, "There's this thing that people are experiencing, and they don't know how to talk about it. They don't know how to seek help for it." That got me into grad school.

I've talked about this personal experience pretty openly before. Just to buffer where I'm going with this, it was actually a week after I got into grad school that the worst experience happened in my life. I lost my brother to suicide, so that was life changing. Basically, that shifted my mindset of my interests in terms of, for so long I concealed a lot of these personal experiences and these family experiences, and then when I entered graduate school for the first year or two, I was experiencing understandable distress from this tragedy that happened in my life.

I thought it was really paradoxical that I didn't feel like I could talk about these experiences to my colleagues, even though my colleagues were themselves mental health professionals. I was interested in clinical psychology because, as I understand it, our field strives to understand, treat, help, and reduce stigma towards mental health difficulties. I had had this very salient experience early on in my career, and I also felt like I was getting messages as Maya was just talking about, of not talking openly about them or concealing them because if I maybe brought them up, maybe I would get opportunities taken away from me.

A lot of this was implied. A lot of it I felt was implied because we don't talk about this and because there's a culture of silence, there's this culture of fear of why aren't people talking about this. I think that led me to ask these questions more openly about why aren't psychologists talking more about their own mental health, and then also what can we do about it. Mitch, as you just said, half of people in their lifetimes, regardless of you're a psychologist, are going to have these experiences.

Dr. Mitch Prinstein: Andrew, thank you so much, and thank you for leading by example so wonderfully. It's ironic because we are a field, as you say, that study stigma and is aiming to reduce stigma overall. What do we know about the factors that lead to stigma and the strategies that can be used to combat it from our own research literature? It might be good to think about this. This time, wearing our hats not just as scholars but as some of the people who may be among those making some of those automatic assumptions or missteps and how we end up reacting to information about those experiencing mental illness in our professional community.

Dr. Sarah Victor: I really think that scientifically speaking, one of the things we think a lot about in our research is sampling bias. Who is our sample and are they representative of the people that we care about studying? That is such a common issue in this area of stigma in disclosure within graduate training even going back to Cohen and Cohen in the '80s, talking about the clinician's illusion where we as people seeing clients are going to see a sample of people whose illnesses are more intractable, that recur more, that require more treatment on average than the general population.

I think that that furthers some of our own biases about what it means to have depression or anxiety or a substance use disorder. Because of that, when somebody in our community, in our field, is thinking about disclosing that, our views of what that can look like in terms of recovery are skewed because the people who recover and who don't seek treatment or who seek treatment once and don't come back are not the ones we're seeing so often in clinic.

I think that speaks to just the need for more representation of people in the field who are in a position of doing really well and managing their symptoms and recovery and that that is an option, that is a possibility, that is a thing that exists in the world, that if you're doing primary clinical practice, your sample of who you're seeing is you're going to see fewer of those people.

Maya Nauphal: I think for a lot of people, we're not necessarily aware that we are holding these biases. The messages we receive about what it means to struggle with your mental health, the stereotypes associated with different disorder groups are so prevalent and so embedded in our understanding of mental illness that a lot of times we don't even think to challenge them. We're taught stereotypes or we're exposed to stereotypes.

There's some research that shows that a lot of mental health professionals don't even realize that some of the things that they believe are rooted in unhelpful false negative views of mental illness. I think we even have a problem before which is this idea of, a lot of times, we're not even recognizing that there is a problem to solve, which I think was part of the impetus for this conversation.

Andrew Devendorf: I think one driving factor too is our field is embedded within the DSM-5 framework, which was developed decades ago by people without experience, and it was also developed as a way to try to make psychology more medicalized. We took mental health and put it into this medicalized system where we define these experiences with mental health as more disorders. They are useful to define as disorders and diagnoses to help people get care, to help people provide an explanation of what is going on.

Also, the DSM is inherently a deficits framework. It doesn't acknowledge the function of some of these experiences, or it doesn't appreciate a lot of the contextual reasons for why people might develop them or what might be going on.

I think inherently in training, because we're trained in this more deficits framework or even some of the stereotypes, we're talking about of the training cases that come to my mind, there are always people who are doing really, really badly and it's always about seeing the person when they're at their lowest point. I can imagine that because we don't have greater representation about the people who are doing well or using their experiences in a functional standpoint. That's probably also contributing to the purely negative reactions people might have.

Dr. Omar Gudiño: [crosstalk] There's a piece that Andrew just-- Sorry. There's a piece that Andrew just mentioned that for me is really key, which is, what are the explanations that we have, and that if we just rely entirely on diagnoses, the explanations for why these things happen and what maintains them and what makes them better, those aren't really explicit. I think there's things we can borrow from our advances in cultural responsiveness and cultural competence where it's really about acknowledging some of these biases and really working to explicitly understand what kids or families, how are they understanding this and how do we get better at communicating how we are understanding it.

We talk about a case formulation a lot, but it's really being able to have a case formulation that acknowledges the potential for bias, and then being really good at communicating that explicitly so that it's clear how we're understanding, why we're assigning a disorder, why the disorder may not capture everything, and why these interventions make sense. I think connecting those pieces is one way to start providing more corrective information. If we're explicit about what we think and don't think, that's a really good start.

Maya Nauphal: I think to build on that, Omar, that not only do we not always make explicit, the why behind certain things manifest the way they do, but oftentimes when we are working within a medicalized model, we're also focusing on factors that are inherent to the individual that are biological, that are unchangeable. There's actually some research that shows that more of these biogenetic explanations of mental illness contribute to more stigma, more perceptions of unpredictability or dangerousness. Even in our hyper-focusing on medical models, we're actually in some ways perpetuating some of these stereotypes.

Dr. Michaela Sweet: I think one thing I would also add too is when we're talking about diagnosis and the whole context of this medical model, we also think about diagnosis as labels, that we assign, that a doctor, a clinician assigns someone. Omar, I really appreciate what you're speaking to in terms of cultural responsiveness. I think there's a lot that's really important too about asking people about their feelings about certain labels, being given certain labels, how they relate to these diagnostic labels, these diagnoses, how it impacts how they see themselves, how they worry other people in the world see them.

I think we don't always do such a nice job of that either, asking people what their own feelings are about being assigned or given a diagnosis. I'm aware too that in my role, I identify very strongly as a psychotherapist, as a clinician, and also as someone who does a lot of training and teaching and supervising folks in the clinical sphere. I'm always thinking about language that we're using, clinician to clinician, also licensed person to trainee, clinician to patient. All of these complex relationships, and how they impact the relationship too. The language that we're using, how they impact ourselves and the people we're working with.

Dr. Mitch Prinstein: Michaela, I'd like to pick up on that and extend it just for a moment. I think that the way that we approach thinking about diversity and compassion and respect is to, I personally feel, to just non-defensively listen and learn. In that spirit, I wanted to ask, what are some ways that people might have said things or done things that have inadvertently reinforced the notion, the stigma, rather than help people feel safe and comfortable talking about their experiences or their needs or their abilities related to mental illness? Anything that you've heard, any of you have heard from others that would be good teaching moment examples of, that's the kind of thing that maybe people don't realize actually makes the stigma a little bit harder.

[crosstalk]

Dr. Michaela Sweet: Great question. Sorry, go ahead.

Dr. Sarah Victor: Can I jump in, and would you let me talk about your uncensored guide?

Dr. Mitch Prinstein: Yes, please. Yes.

Dr. Sarah Victor: I'm so thrilled with the new update, and I think this is a great example of-- as folks listening might or might not know, Mitch has a very thorough, extremely useful guide for Mitch's uncensored guide to getting into graduate school. I recommend it to anybody in my lab

who's interested in applying to graduate school, trying to figure out what field they want to go to. Amazing resource, amazing advice.

In the prior version, there was a note about red flags, things that might get you kicked out of the pool. One of them I think was putting personal information about mental illness in your personal statement, which is true that it is something that does sometimes lead people to face inactive stigma or discrimination.

It's not that what was in the prior version was inaccurate, but I noticed in the most recent version, you've updated it to include more of a paragraph about we recognize people have these experiences. It's not that if you have these experiences that you're not fit to be in graduate school, but it's how you talk about them and when it's appropriate to disclose them. I was, "Oh, my heart." I'm so happy because it's the same information. It's very important information to give applicants to say, "If you share this, there's risks involved."

We don't want to swing the pendulum to say, "Well, we're just going to pretend stigma isn't real because we wish it wasn't." To see it change and say, "Yes, of course, it's not that you having this experience is bad. It's just you have to be thoughtful about how you talk about it." I felt it was a really lovely way to address some of that. Obviously, the prior version was not intended to make anybody feel like they shouldn't have that experience. I think it's just a great example of how we're all learning, and I love it, and I'm so excited about this version.

Dr. Mitch Prinstein: Thank you, Sarah. I would be remiss if I didn't mention that 100% of the reason why that change was made was because Andrew came up to me at a conference and said, "Here's a way to learn about--" I said, "You know, I never, ever thought of that, but I'm going to change it immediately." I don't remember how quickly I did it or not, but hopefully as fast as I was able to get to it because I learned and I was very much hoping that people would not be steered away. Thank you for that example.

I imagine that there are many other examples, too, of where lots of people can learn that, gee, they might be saying something in class or to a peer who's in graduate school or something. Whoops, that accidentally is offensive, and people didn't realize it. What might be some of those cues and ideas for folks to be able to learn from?

Andrew Devendorf: I have some examples. I think all of us have talked and we have our little examples, which is not a good thing, but I feel like I see it in supervision or maybe even casual conversations in training settings about cases. People will unintentionally use phrases that are just like, "That doesn't sound good." I've heard people say, "Man, I just don't like working with bipolar people." Or people use the word borderlines like, "The borderlines are at it again."

I think where that might be coming from is certain clients are inherently-- this is therapy. We're working with people at their most challenging times. It can be frustrating if we're not making progress or we're not seeing gains. Also, when you use those general labels, other people hear those things, and you might not know who in the room also has identified with those labels or people who know people who identify with those labels.

Again, I don't think it's effective to reduce stigma to be like the language, please, but to have a nuanced understanding of how our language does affect our beliefs and our ability to have compassion for people. I think similar to the themes that others are talking about, when we give these labels and we say them in a pejorative way, we're othering people. Let's think about how that also gives us hope of being able to work with those people or provide compassion to them. Those

are just some examples I've heard of just-- so considering the language and categorizing that we're using in clinical settings and also even just casual conversations from peer to peer.

Dr. Michaela Swee: To add to that, Andrew, I think what you're saying is really important, and overt use of certain types of language is very powerful and it has a significant impact on people. I also find it really interesting how nonverbal cues also impact this thing. I think a lot of this happens in big spaces. I'm very curious about how social psychology comes into play. People want to be included. They don't want to be excluded. They don't want to be cast out. They don't want to be seen as other or as an abnormal.

I do a lot of research and clinical work around shame. Shame and stigma go right hand in hand. Thinking, too, about noticing what are our eyes doing in response to things that people say. Do we laugh or smile in response to things that are said? There are a lot of ways other than just the language we use that we convey messages and beliefs that are then interpreted by people in terms of what we think about things or what we think about certain diagnoses, too. I think that's really important.

I feel really fortunate, and I think about this now again in my role as training a lot of people now, a lot of future clinicians. I felt really fortunate to be mentored and guided early in my career in training by supervisors who really emphasized the importance of sincerity and intention in how we talk about people, talk about their experiences, the way that we react, again, non-verbally, with facial cues, posture.

I'm also thinking a lot about-- sorry, it's slightly tangential, but I do a lot of work in compassion-focused therapy. Integral in that therapy is this idea of how we show up with our bodies in the room as well. I'm thinking a lot about what it means to show allyship and understanding and compassion as opposed to judgment and criticism. There's so many different ways, I think, that that can show up and that we can combat it.

Dr. Mitch Prinstein: What are some things-- Oh, sorry. Please, Sarah.

Dr. Sarah Victor: I was just going to say two related examples because I can more readily come up with examples of things that maybe weren't well-intentioned, but that's a separate question. I think in terms of well-intentioned, what I've seen, I've seen this happen in two ways where a supervisor or a colleague has said, "Well, you don't understand what it's like in relation to a client's experience." It's like, "Well, you don't understand what it's like to not be able to get out of bed in the morning."

I'm like, "Well, that's an assumption that you're making about me." It's coming from a place of wanting to support empathy towards that client but making assumptions about my own experience. I've also seen the flip of it, whereas people know more about my lived experience, they'll say, "Oh, well, you get it. You get what this client is going through because they have the same diagnosis as you."

I'm like, "Well, no." There are some experiences that this client might have that might be similar to some of the experiences that I have. They are a unique individual, and they are an expert on their own life. I would never say, "Oh, because I have a diagnosis of depression, that your experience of depression is the same." There's so many ways that that, just even diagnostically symptom-wise, that can vary. Also, obviously, in the case of your psychosocial circumstances, your culture, your environment, what supports you have, how you think about that diagnosis. I think I've seen it in

both ways, either the assumption that I can't know what a client is feeling or the assumption that my experience must be identical.

Dr. Michaela Swee: Just briefly, Sarah, what you just said actually I think is really important for those of us who teach. If we teach abnormal psych courses or psychopathology courses, I think it's really important to talk about the heterogeneity of these experiences and to very openly and humbly state at the beginning of the course and throughout the courses or supervision groups or whatever the context is, you may have experiences that look like this or know people who have experiences that look like this. You may have experiences that look very different.

I think that's important, as opposed to just saying-- we're talking about the DSM. This is what this disorder is. This is what it looks like every time and in every person but being open to seeing difference.

Dr. Mitch Prinstein: We have a question from someone viewing right now, and they offer a podcast. They're psychologists that offers a podcast, and they discuss their own experience with mental health in the course of their podcast, to which listeners will often respond, "You're so brave for discussing that." From the question, it sounds like that sometimes can have a backfiring suggestion of, one would have to be very brave to say out loud that one has experienced symptoms.

In fact, if someone said that they were diabetic, it might be less likely that someone would say, "You're so brave to have acknowledged that." It actually reinforces the idea that it's stigmatized to say things. What are the best ways to either positively reinforce, when you're in a professional setting, to positively reinforce when something is said that destigmatizes, or to gently note when something isn't actually reifying or exacerbating the statement?

Maya Nauphal: I think that's such a good question because, on the one hand, I totally get how the implication that it's brave to say, I have depression, reinforces this idea that there's something wrong with saying it out loud. There is courage that comes with it to share something in an environment where it is very likely that other people will react negatively or that people will perceive you differently or will have certain judgments about your professionalism, your capability, or your bias or unbiased nature of your work.

I think being able to acknowledge that it takes courage, not because there's something inherently wrong with having depression, but it takes courage because the context with which you are sharing that information is one where there are potential negative consequences, and so I think being able to articulate that removes a little bit of the perpetuating stigma.

I also think giving people feedback that's very specific, and saying, thank you for sharing that, that was helpful for this reason, or it changed the way I think about this because X, Y, Z, as opposed to these blanket statements of like, you're courageous or you're not. Being able to say like, this is why this is important and how it relates to my own experience and what it's like for me to receive this information from you. That's what comes to mind.

Andrew Devendorf: I want to come in and highlight the, put the reinforcement of it, and Maya, I love what you said about the specific reinforcement too. This year I'm on clinical internship, I'm at the Seattle Puget Sound VA. In some of my work, I've been practicing with my clients very selective small opportunities for disclosure. Again, I think when people think about disclosure, they think about either somebody just sharing everything about their life. What I'm thinking about with disclosure is just like a way to find a human moment to connect with my client.

I was working on the pain clinic recently, and one thing that I identify with my clients is I have chronic migraines. I had a brief disclosure of like, "Oh my God, I have chronic migraines. I've played the medical Merry-go-round. I've been passed on from provider to provider. I think I can hear from where you're coming from." My supervisor listened to the tape and she noticed that, and she brought that up and that was very specific positive feedback of that disclosure.

I think the more that we can-- one, I think we need to strive towards a place where disclosures don't need to necessarily be treated as something to bring up. Hopefully, we get to a point where our culture is just like, we talk about these things like other types of identities, we don't make the biggest deal about them. Also to help with the norms about what is okay and what is not okay, is to provide that specific feedback about reinforcing when it's good to do this stuff. Also even noting explicitly the boundaries of maybe when it's not as appropriate.

One last example is personal statements. We inherently call them personal, and so they almost invite people to have these personal disclosures. I think without mentoring, most people do that, but then people on the sidelines might get surprised or taken aback when a student writes about their personal connection for why they want to enter the field and view that as inappropriate.

I think I'm of the perspective of for personal statements of like, it doesn't need to be the full paragraph, but also just having more clarity, transparency, and specificity of what these personal statements are asking for to provide those open instructions about what are people expecting and hoping for. I think that's a way to maybe reinforce and also clarify the appropriateness of disclosures.

Dr. Mitch Prinstein: [crosstalk] One of the things that we-- Oh, sorry. Please.

Dr. Omar Gudiño: No, for me, that's such an important point that it's really a nice way to highlight how we're socialized into the profession. You're saying there's these values that are there and maybe the values around self-disclosure, the values around deficiency, the values around should we be connecting with clients on a personal level. Those are all things that have been there throughout the history of our profession, and they've changed.

These days we might say disclosure is bad, but we forget why disclosure was initially bad, and we forget to really explain why disclosure may not actually be bad under current practices or, as Andrew was saying, where do we define that problematic self-disclosure? It goes back to this idea of being really aware of what are the values within my profession. Why do we think efficiency is a priority? Why do we think seeing results quickly as a priority? There are parts of our field where personal collection might be the priority.

Really being able to connect those pieces rather than saying, this was good therapist behavior, bad therapist behavior, to be able to work with supervisors or with colleagues to really think about, why do we have these attitudes and how does that fit into this very specific example?

Dr. Mitch Prinstein: Omar, you're going exactly where I was going. Thank you so much. I guess what I wanted to say was, I think that we have learned that when we're trying to change stigma or we're trying to increase compassion, it tends to not work so well if we start vilifying those who hold a particular point of view. Let's acknowledge without judgment that there might be some generational or cultural or professional differences over the years that might contribute to stigma different ways. Let's acknowledge that those are fair ways that people might have developed a stigma, and also an opportunity to invite folks to think about the current knowledge that we have and to destigmatize.

Does anyone want to comment on some of the ways in which stigma might have come about or the ways in which they might be reinforced within communities, including immunities of psychologists?

Dr. Sarah Victor: I have an example that I think really speaks to this. When I was in graduate school, I was at a social event with a bunch of people in the field. I was speaking with the director of clinical training who is not my director of clinical training, so I'm just not trying to throw them under the bus. This was somebody from a different program. They asked about what I studied and I said, "Well, I studied non-suicidal self-injury." This was a person who was known to be a very good clinician, very focused on clinical training, saw clients privately in addition to being DCT.

He said, "Oh, that's really interesting that you study that. I don't treat the borderlines." Already I'm like, "Oh, why?" He said, "I don't treat the borderlines because once I treated someone and I didn't know that she was borderline, and then she killed herself, and that's why I don't treat the borderlines anymore." I was just standing there like, what am I supposed to do in this situation? The level of, A, just a misunderstanding of what self-injury is and the fact that it's not unique to borderline personality disorder, the referring to an entire group of people as borderlines.

I was really mad after this exchange. I was a very polite person, but I was very mad after. Then as I continued, as I thought about it, I was like, okay, this is coming from probably a lot of this person's own emotional experience about losing a client to suicide, which is awful and no therapist ever wants to experience. Often there's a lot of shame and a lot of feelings of guilt, like often misplaced guilt about, "Well, I should have done something different."

I've come to think about that now, of course, the way that this person communicated this was not appropriate and not effective. Coming from a place of probably fear of, "Well, if I had treated this person and this really horrible outcome happened that I was trying to avoid, and they had this diagnosis that maybe I already had some stigmas about, well, if I don't treat people with that diagnosis, then that protects me from having this painful thing happen again."

Recognizing, okay, it probably actually is good for this person's clients that maybe he recognizes that he's not an appropriate provider for people with this diagnosis. Also, can we provide better supports for people doing therapy when they encounter really challenging clinical experiences, whether it's a loss of a client to suicide or a client who attempts suicide and survives, or even just other really challenging outcomes for a therapist.

How do we support providers in working through that process so that they don't end up furthering this, "Well, let me put this label on this person and this whole group of people because that's a way to protect myself." Obviously, a challenging situation, but I think now I have a little more understanding of where that would come from.

Andrew Devendorf: Sarah, I really admire that story. I don't think I've heard you share that one before that. I think that's a powerful one. It was making me think about Mitch's question about how do we recognize these generational differences and approach these conversations with compassion and openness. I think that was, one, a great demonstration of that. Two, I just want to highlight, yes, I don't think it's effective to change people's minds by just shouting at them like, "Say this, do this, don't use this language."

To do what Sarah just modeled of taking perspective of wherever they're coming from. I also buy into a lot of the social psych research that stories change minds, facts don't necessarily change minds. I think facts and science and data incredibly valuable and we can use those within stories,

and also just having an open conversation with people and hearing where they're coming from with that non-judgmental approach can be really powerful.

Then you can more easily find the common ground of like, "Well, why are certain generations having this reaction?" It must have come from somewhere to why we don't actually talk about these things. What are the instances? I think that's helped me also just develop more of a compassion for why things are the way they are. Then I also think it's just more strategic for identifying areas for like, "Okay, well this is what was, this is how things are changing. Here's how we can have these conversations more effectively."

Hopefully, this is a good example. Mitch, just thank you so much for also just hosting this in the first place. I think this is a really good start of putting this type of conversation out there from the get-go.

Dr. Michaela Swee: Can I also just add too, I think Andrew and what you were saying, and Sarah, the anecdote that you shared, I think it's important to remember as psychologists that our minds are geared toward thinking heuristically. All good, all bad categories. What makes sense, what doesn't make sense? How do I make the story as Andrew, as you were saying, how do I make the story fit, the story makes sense?

Especially for those of us who have been trained in the cognitive behavioral model, we're used to working with this idea of cognitive distortions, unhelpful thinking patterns. I think it's important for us to remember to challenge our own thinking when we get into very all-or-nothing over-generalized problematic, harmful ways of thinking.

Also, I want to come back to this idea of compassion because we've used this word a lot today or a few several times. I think the way we think about what compassion is, is really, really important. Again, this is my whole area, compassion, compassion, but it's really about attuning to ourselves or to one another in moments of suffering and thinking about how we can be helpful rather than harmful.

I think that if we use compassion as a guiding compass in terms of what we're talking about, how we're relating to each other in all different spaces and environments, how we're talking and relating to people who are suffering, I would hope that that also is going to impact, if we can really get back close to that intention, impact how we do that, how we relate, how we talk to each other.

Dr. Sarah Victor: That too brings up this amazing point that we are all trained in clinical psychology and other related fields to work with people who might have views that are very different than our own in ways that might be relevant to treatment or not relevant to treatment. We, of course, learn that you don't go into the therapy room and say, "That's a wrong thing to think."

I think we can use a lot of those skills that we have for being curious when somebody says something in a session, whether it's stigma about a mental health condition that the client has or that somebody else has, or a view of other people in the world. Certainly, it comes up where clients might say something that is racist or sexist or homophobic, and that the way to approach that clinically is generally not to say, "That's a thing you can't say in therapy," but to say, "Where does that thought come from? What have your experiences been that makes you believe that?"

Gently having that conversation, which I think a lot of that can be very easily paralleled in working with our colleagues and people in training settings instead of saying, "That view is stigma, and

you're wrong," to say, "Well, what makes you think that? My experience has been different with people with that label or that group or with that diagnosis." We have these skills. [chuckles]

Andrew Devendorf: I like to remember that the whole-- I don't know if I identify with this for everything, but the whole blank slate, I don't think people are born wanting to stigmatize mental health difficulties. They're not born with that awareness. To Sarah and Michaela's point, this must come from somewhere, and let's explore where it's coming from and how we can work with it.

Maya Nauphal: Also, I think want to hold the other side too of, it is okay to be angry and frustrated in the face of experiences of stigmatization and oppression. It's a dialectic of needing to say, "We're not assuming mal intent. We are trying to think of ways to change beliefs, to change attitudes that are most effective and most compassionate to the people we're working with, and it is also okay to be really angry or hurt or frustrated or whatever emotional experience you have when you are confronting people who are perpetuating beliefs that might be harmful to you or to your clients."

I think, Sarah, you were mentioning, that conversation made you very angry, and also you were trying to hold a compassionate stance. I think that's also important to not erase that part of the experience too, because it's valid and it, a lot of times, fuels the work that we do.

Dr. Sarah Victor: I will say in the moment, I was not feeling very compassionate. I was mostly feeling angry. [chuckles] I don't want to stop people like, "Well, if I can't get this compassion in the moment, then that means that I'm not doing it right." In the moment, the reason I didn't say anything snarky back was because this person was a DCT and I was a grad student and I knew people that were in their program, and I didn't want to be the difficult person showing up. It's only over time that I've been able to think about it a little more. It's also okay if in the moment you're like, "No, this sucks. I don't like it."

Dr. Michaela Swee: I have to speak about this because it is really important just to debunk common myths about compassion. It doesn't mean forgiveness, it doesn't mean excusing something that's harmful or not appropriate. I'm actually thinking, Sarah, with your story about self-compassion in terms of owning your anger. I'm angry and I have a right to this experience right now. It makes sense that I'm experiencing this.

Then also what's going to be helpful to me in this place? Look at you and your research career and your-- I think that compassion is really important in that way. It doesn't mean just forgiving or letting go or excusing it. It actually means being in touch with what the real feelings are that are coming up, and then thinking about how we can be helpful rather than harmful to ourselves and to each other.

Maya Nauphal: Yes, and I want to also-- [crosstalk]

Dr. Mitch Prinstein: Oh, sorry. Go ahead.

Maya Nauphal: Quickly circle back to, I think Mitch, your question of how do we shift attitudes in ways that are effective and compassionate, and Andrew, you made the really good point that Sarah's story in and of itself wasn't effective way to do it. We know from research that contact-based interventions are really effective at shifting stigma. We also know that clinical psychologists with lived experience of mental illness tend to hold less stigmatizing attitudes than folks who don't.

We also know that contact-based interventions when they are with people of similar social groups to you, are more effective. There's this untapped potential, I think, of centering and pushing the voices of those with lived experience within our field as a way to reduce stigma. Not to say that it is on the shoulders of folks with lived experience to carry this burden, but I think this conversation, hopefully, is modeling the power I think that this particular way of intervening can have.

Dr. Sarah Victor: I think-- [crosstalk]

Dr. Mitch Prinstein: Absolutely. I'd like to-- Oh, sorry. I was going to say I'd love to plus one a couple of thoughts and ask you all a question. I want to plus one the idea that when one has just been offended, [chuckles] it is incredibly difficult to immediately be empathic towards that person, and the experiences that you are describing, and Sarah, that you gave an example of are very difficult for somebody to do.

If folks are listening and aspiring to do that, it might be something that is challenging, that is hard to do, that takes time to do, and it's okay for someone to take care of themselves and not feel the burden of having to also be the empathic teacher at the same time, which is what I hear you saying. I just want to plus one that. I also wanted to just reinforce the notion that, yes, I think as a planet we have been yelling and judging a lot more than we have been listening, and I think that we would be a much happier people if we did the opposite. I just want to plus one that sentiment as well.

What I wanted to ask you with the time that we have left, we've been talking about the stigma and discrimination towards those who have experienced mental health symptoms. I guess I want to flip that on its head for a moment and really ask, what are the reasons why we should welcome and celebrate that the perspectives of people who have experienced mental health symptoms are interested and could assist the fields of psychology and others.

Let's talk a little bit about the strengths, benefits, and the needs that our field has to be listening to people who have been experiencing mental health symptoms, not just who are our patients, but who are psychologists and researchers and teachers. What do you think?

Andrew Devendorf: I think there's several that a lot of us can talk to. The first thing that comes to my mind is, just to summarize what we're already talking about is sharing stories can really normalize and humanize this experience. For clinical psychologists specifically, if we present ourselves as above these difficulties, then we're probably less relatable as a field. Also, we're not, Mitch, as you're saying, even leveraging our own strengths and how we can use our own experiences in our work, so I often bring up that our field would not be as far as it is without people with lived experiences.

There's so many great examples. Marsha Linehan talks openly about using her experiences to develop dialectical behavioral therapy. Thomas Joiner, a leader in suicide prevention, writes about how he lost his father to suicide. Stephen Hinshaw talks about how he experienced mental health stigma within his family, and now he's a leading figure in reducing stigma. I can go on. It's not even just clinical psychology. There's even people who do this self-relevant research in other fields.

We have data actually that over half of clinical psychologists and trainees have done this self relevant research or research, so the people are there. Also, we found that the disclosure element and people being okay with people talking about these experiences is less appropriate. We already have pretty good representation of people with lived experiences at the research level, and so let's continue to talk about the value and strengths because we're not going away. We've been here since our field started.

I'm curious to hear what others think about the strengths element because I think also making the strengths part more of the conversation versus the deficits, that's just another more natural way to shift the conversation.

Dr. Sarah Victor: I think there's so many reasons. The first is, we agree as a field that we need a workforce that has experiences and identities and values that we can treat and serve a hugely diverse set of communities with lots of different experiences. If we're saying that a huge chunk of those experiences that we are supposed to be helping people with, we're going to select out from who we're training, it really doesn't make any sense if we're thinking about, we want to understand these people's experiences and support them, but you can't then have those experiences.

I also think it's valuable for clients to understand and see like, "Oh, my psychologist has had these experiences," or there are psychologists who have had these experiences, or people to say, "If I'm interested in these things, it doesn't always have to be in the client chair," so to speak. Even just seeing examples of folks with experiences of mental health difficulties, surviving and thriving in lots of different fields and lots of different domains shouldn't be any different than that.

I also think it's really valuable in terms of understanding and improving our clinical work and our clinical supervision. A lot of the supervision I do and a lot of things that I think of are informed by my experiences as a client, whether they were good experiences or not so good experiences. That's just another source of data. That doesn't mean I throw out everything I learned in graduate training and in postdoc training, or that I throw out all of these theories and models and evidence-based, but it's another source of information that can prove really valuable. I think all of those things are strengths.

Dr. Mitch Prinstein: Other thoughts on the perspectives that are offered in our field by those who have experienced mental health symptoms, and why we might actually lean in to embracing and hearing and valuing those perspectives rather than reinforcing stigma that systemically silence those voices.

Dr. Omar Gudiño: I apologize for the technical difficulties before, but if this hasn't already been covered from a-- I do a lot of work in community-engaged research, and that's a place where we really think about the importance of really understanding the problems and working collaboratively to develop questions, to develop methods, to develop the science and how that really reinforces the quality of the work that we do, both clinical application and scientifically. I think we're missing that when we think about personal experience with mental health. I'm sorry if that's a repetition of something that was already said.

Dr. Sarah Victor: No, that's great. I was going to say, too, that I think for development of research questions, people with these experiences are often the ones who are saying, "Y'all scientists are missing something important. You should be studying X instead of studying Y." That's incredibly important when we're studying anything or any community, but especially people whose experiences have historically been marginalized or silenced or stigmatized.

If we're making a concerted effort or we should be making a concerted effort to listen to those voices and those priorities, than to say people who are already in the field who know what's in the science and who might have that lived experience to know what's missing, those people can't tell us about what's missing based off of their lived experience, but we value it, just also doesn't make sense to me.

Andrew Devendorf: For me personally, I think talking to other people who have personal connections to their work. Clinical psychology, it's not an easy field to get through. We are, in my opinion, overtrained to do a whole bunch of different roles; clinical work, teaching, research, mentoring. It's not a very well-paid job for a long time. We have to get through grad school. I think I myself often ask, "Why the heck am I still doing this?"

It comes back to, it's the passion and mission of, I'm very tied to this. I feel like people aren't talking about this enough in effective ways. I think there's a lot of suffering where there doesn't need to be suffering. I think it's important to have people with buy-in. I don't think everybody needs to have personal experiences. I'm pro-diversity of also people without experiences. Right now, I think the pendulum is too far on one side where people aren't encouraged to leverage their strengths or to have that recognition of the strengths. My guess is that a lot of people have buy-in that helps them overcome a lot of the inherent barriers of just pursuing a career in clinical psychology, and that's really valuable for us.

Maya Nauphal: The more we focus on strengths, the more we can help counter the internalized stigma that a lot of people in the field carry, which contributes to burnout, which contributes to a sense of disempowerment, which then impacts the work that they do. I think also just for the wellbeing of our workforce, this is something that's so important to focus on because we matter.

Dr. Mitch Prinstein: I want to thank this extraordinary panel for suggesting this topic and then providing such an incredible discussion on something that should have been discussed a long time ago. Inspired by this panel and by your leadership, this talk will be posted along with a couple of articles that are coming out very soon in the APA monitor to talk about mental health stigma and disclosure of mental health experiences and one's entry into the field. Take a look out for those links along with this video. I want to also thank everybody who is listening live or on recording for joining us.

You're going to receive about a one-minute survey to complete after this broadcast. We love your feedback. Also, any input you have on topics you think we should cover, you can just send those to science@apa.org. Last, just wanted to invite you to subscribe to *Science Spotlight* so you can get all the relevant news about funding opportunities, progress, and work that we're doing to benefit your experience as a psychological scientist, and to increase the impact of psychological science. Thank you all again so much for joining us. Thank you to the panelists, and have a great rest of your day.