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Stigmatizing our own: Self-relevant research (Me-search) is common but frowned upon in clinical psychological science

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Conflicts of Interest: We have no conflicts of interest to disclose. All the same, we believe the topic of this manuscript warrants a positionality statement. The authors conduct mental health research and have either personal experiences or close connections to people with lived experience in this area. Several authors identify as people who conduct self-relevant research. While we believe many factors drive our motivation to study our given research interests, we do believe 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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Contributions: ARD and SEV conceptualized the study concept and designed the survey. ARD designed the measures and vignettes to study SRR. SEV administered the study. ARD and SEV curated the data. ARD conducted the primary data analysis and interpretation, with data cleaning help from SEV. JR, RM, SL, JM, and DS provided supervision. ARD drafted the paper, with SEV, JR, RM, SL, JM, and DS providing critical revisions. All authors approved the final version of the paper for submission.

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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 (SRR; “me-search”) and attitudes towards SRRers in a representative North American sample ($N = 1,776$) of faculty, graduate students, and others affiliated with doctoral programs in clinical, counseling, and school psychology. Over 50% of participants had conducted SRR, and those from minoritized backgrounds were more likely to conduct SRR. When judging experimentally manipulated vignettes, those who had not engaged in SRR made more stigmatizing judgements of SRR and SRR disclosure than those who engaged in SRR. Psychologists and trainees had more negative attitudes towards SRR on mental health topics (suicide, depression, schizophrenia) than physical health topics (cancer). We discuss how prejudice toward SRR 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” (SRR), which is the pursuit of research by those who have a lived experience with, or close connection to, their research area (Devendorf, 2020a).

In 2011, Marsha Linehan publicly shared that she used her personal experiences with mental health treatment to fuel the development of Dialectical Behavior Therapy (DBT), 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 (SRRers) today (Devendorf, 2020b; Gardner et al., 2017; Victor et al., 2021). 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 research and reduce stigma. In his book, “Why People Die by Suicide,” Thomas Joiner (2007) disclosed that he lost his father to suicide, an event that shaped Joiner’s life and informs his devotion to understanding suicidal behavior. While these disclosures by leading figures in mental illness research are compelling, they also underscore the lack of systematic data regarding the prevalence of SRR and how it is regarded by other members in the field.

After reviewing the value of studying SRR, we document the prevalence of SRR in a North American sample of faculty, graduate students, and others affiliated with clinical,

counseling, and school psychology doctoral programs. These data afford comparisons of how psychologists view SRR as a function of the research topic (e.g., suicide, schizophrenia, depression, and cancer) and relative to non-SRR research, and whether (and where) psychologists believe disclosure of one's personal ties to their research is appropriate. We conclude by exploring if SRRers are more or less accepting of other SRRers relative to those who have not engaged in SRR.

Meta-Comment on Terms: Me-search vs. Self-relevant Research

In this manuscript, we employ “SRR” to describe our subject rather than the more commonly used term, “me-search.” While these terms have similarities, several commentaries 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 the authors' experiences, we have observed – and regrettably participated in – conversations in which academics used me-search as a derogatory label for others, which may include conjectures about a researchers' history with mental illness (e.g., overhearing audience members at conference try to guess whether a substance use researcher has previously struggled with a substance use disorder; Devendorf, 2020b). 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 like a substance use disorder.

To reduce the potential for these negative repercussions, SRR was proposed as a more descriptive and neutral alternative to “me-search” (Devendorf, 2020a). The current investigation 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 the term “neutral,” and just 12% “liked” the term. By contrast, when asked about SRR, 19% of participants “disliked” the term, 48% found the term “neutral,” and 33% “liked” the term. Our results showed that SRR was the much-preferred term to me-search, and we advocate for the use of SRR moving forward.

Why Studying Self-relevant Research is Important

A formal study of SRR can benefit the field of clinical psychological science in several ways. Understanding how common SRR 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 SRR have unique assets (e.g., perspectives, experiences) that enhance their research enterprise. From this perspective, identifying and recruiting SRRers may be one mechanism toward giving attention to understudied, though worthwhile, topics (e.g., research on LGBTQ topics), which may be more likely pursued by researchers with lived experiences. For example, recognizing stakeholders – like 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 SRR among those in the field would facilitate efforts to improve acceptance and mentorship of people who engage in SRR (Victor et al., 2022a). In these respects, studying SRR 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 SRR in the absence of formal research. What we can infer is limited to circumstantial evidence drawn from commentaries (e.g., Gardner et al., 2017), advice guides (e.g., Devendorf, 2020a), and survey research (e.g., Appleby & Appleby, 2006), all of which may be outdated and lacking representation of the field's SRR views. These sources do not provide conclusive answers about how the field views SRR, but they provide clues that suggest psychologists and trainees have conflicting attitudes about SRR and its disclosure.

On the surface, the pursuit of SRR appears to be largely disfavored and stigmatized by scientists (see for commentary, Gardner et al., 2017). Stigma occurs when people express prejudice (e.g., agreement with negative stereotypes) and support for, or engagement in, discrimination towards stigmatized groups (Rüsch et al., 2005). Scholars have noted that prejudice toward SRR may manifest as agreement with stereotypes that SRR is biased, impartial, 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 SRR (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 (Harris et al., 2020). In clinical psychology, widely used graduate application resources advise applicants to avoid disclosing personal connections to mental health difficulties (see Devendorf, 2020a, for 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, 2021). A survey of 457 psychology

graduate programs identified SRR as one “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 SRR. Prior to sharing that she lives with bipolar disorder, Kay Redfield Jamison was afraid that colleagues would view her by her illness, and not as a successful psychologist who studies bipolar disorder (Redfield Jamison, 1996). Another example is Elyn Saks, a prominent SRRer with lived experience of schizophrenia. In her memoir, “The Center Cannot Hold: My Journey Through Madness,” Saks described the cautions she received before disclosing that she lives with schizophrenia:

“Dr. 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, 2011a, para 7).

As circumstantial evidence of these risks, it is worth noting that all the referenced SRRers publicly shared their lived experiences after having established credibility and job security (e.g., tenure) within their field. Despite reported fears among SRRers of these adverse consequences (Byrne et al., 2021; Carey, 2011ab), no study has formally examined whether SRR is, in fact, viewed more negatively than non-SRR among psychological scientists.

Although guidance regarding disclosure highlights negative perceptions of SRR (Prinstein et al., 2017), there are mental health professionals and stakeholders who hold positive perceptions of SRR. Several commentaries and studies acknowledge the unique perspectives offered by mental health professionals with lived experience, also known as prosumers (Boyd et al., 2016; Devendorf, 2020b; Kundra & Salzer, 2019; Oberleitner et al., 2020; Victor et al., 2021). For example, people with lived experience and mental health advocates may view SRRers

as having greater insight or possessing intrinsic motivation. The following quote by Marsha 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, 2011b, para 28). When researchers like Linehan disclosed their SRR, their psychology colleagues praised them as brave, courageous, and identified them as commendable role models. To provide more robust evidence about attitudes toward SRR, we investigate whether SRR is viewed more positively or negatively compared to non-SRR.

Disclosure of Self-relevant Research

Disclosure of one’s motivations for academic research is a personal decision with benefits and consequences (Victor et al., 2021), which are often contingent on the reactions of colleagues, stakeholders, and the lay public. However, how the disclosure of SRR 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 lay persons’ attitudes about SRR on veganism and LGBTQ+ topics, with findings suggesting that participants’ own preexisting attitudes towards the research topic moderate the effects of SRR substantially. Specifically, participants who held favorable attitudes towards the research topic viewed SRRers as more trustworthy and credible, and this pattern was reversed when participants held unfavorable attitudes about a research topic. This study suggests a personal connection to one’s research may amplify laypersons’ positive or negative views towards the work, depending on a lay person’s views of the topic itself. In the current investigation, we examine 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.

Current Study

This study set out four aims to launch a novel research program on SRR in a representative sample of North American faculty and graduate students in clinical, counseling, and school psychology fields. First, we documented the prevalence of SRR 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 SRR differently compared to non-SRR. We developed a series of five vignettes to investigate this aim. Vignettes are an effective means to assess stigmatizing attitudes without directly asking participants about socially undesirable beliefs (Link et al., 2004). Four vignettes described a SRRer across different topics (e.g., suicide, schizophrenia, depression, and cancer), and one vignette described a non-self-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 SRR on physical health topics (see aim 3 below). While we hypothesized that SRR would be associated with higher levels of stigma and be viewed as more inappropriate to disclose than non-SRR, we also hypothesized that SRR would be viewed as having more positive attributes (e.g., “A researcher is admirable.”) compared to non-SRR.

Third, we compared psychologist and trainee attitudes about SRR as a function of research topic. On the one hand, it might be expected that psychologists would hold more accepting views about SRR 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 SRR on mental health topics more than physical health topics (i.e., cancer); in turn, SRRers who study physical health topics would be perceived as having more positive attributes than mental health topics.

Lastly, we explored whether psychologist and trainee attitudes about SRR varied as a function of whether participants' were themselves a SRRer (i.e., pursued SRR). We did not have directional hypotheses for this exploratory aim given the paucity of literature specific to this question. Based on prior work and theory, we felt it plausible that results could fit one of two patterns. In one case, it is plausible that SRRers might view other SRRers more positively, perhaps by the process of cognitive dissonance (i.e., having conducted SRR would lead one to accept others who conduct SRR). This would be consistent with other research suggesting higher reported acceptability of stigmatized behaviors by those 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 the possibility that SRRers might be more aware of negative stereotypes associated with SRR and may project those onto other SRRers; 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 the Open Science Framework:

[10.17605/OSF.IO/BCSU3.](https://osf.io/BCSU3/)

Methods

Study Methodology Overview

Detailed recruitment and procedures for this study were previously reported (see for details, Victor et al., 2022b). 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. All materials are uploaded on the Open Science Framework: <https://osf.io/vtxa2/>

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 US 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 (CPA), and Psychological Clinical Science Accreditation System (PCSAS). 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 Director(s) whose emails were listed in the APPIC directory. Training was conducted by the second author/co-Principal Investigator, and a subset of data were 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 DCTs (the remaining DCT being a co-investigator), 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, the study was described as focusing on “research and clinical interests,” with no mention of SRR 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 ($n = 3$), in a non-accredited 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 15-30 minutes on average to complete. Beyond the consent form, participants could skip any item. The survey had three broad aims: (1) characterize prevalence and characteristics of mental health difficulties among psychology faculty and trainees; (2) characterize prevalence and characteristics of SRR; and (3) examine perceptions of the acceptability and disclosure of SRR. Aim 1 is reported elsewhere (see Victor et al., 2022b). This study focuses on aims 2 and 3. We describe items only relevant to this study.

SRR Vignettes. Following completion of consent and demographics items, but prior to questions regarding SRR engagement and mental health experiences, participants were randomly assigned and presented with 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 prior studies of mental illness stigma (Link et al., 2004; Wood et al., 2014).

Each vignette described a researcher with a gender-neutral name (i.e., 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, while stating that “Sam feels a personal investment in their research given their lived experience.” Below is an example of the schizophrenia condition (see for other conditions, <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-SRR condition, in which Sam conducts research on “coping skills for mental health.” This topic has several benefits as a non-SRR comparison: 1) the subject matter remains clinical and thus allows a more direct comparison to the four other vignettes; 2) 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; 3) the vague language of “mental health coping skills” was strategized to be broadly relevant to the sample, without endorsing a specific mental health intervention.

“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 (SSD) Scale for SRR. After viewing a vignette, participants were asked follow-up questions about Sam’s research pursuit on the SSD scale, developed for the purposes of this study. The SSD scale covered both stigmatizing attitudes and strengths-based attitudes. Items were selected based on literature reviews (e.g., Appleby & Appleby, 2006; see Devendorf, 2020b, for review) and consultation with the research team. Stigmatizing attitudes included items that described Sam as “biased,” “selfish,” “irresponsible,” “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 agree with each statement on a 5-point Likert scale (e.g., agree strongly to disagree strongly).

Participants were also provided 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 (e.g., very appropriate to very inappropriate).

SRR Status. After the vignettes and attitudinal items, participants were asked about whether they have ever engaged in SRR. 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 those who endorsed either “yes” response, several follow-up questions were presented including: the extent to which their SRR 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 SRR (e.g., having personal connection before, after pursuing research topic, or both), and whether the participant’s SRR includes mental health difficulties or related topics (see OSF for wording, <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 (SPSS, 2020). Missing data was examined and found to be low (range 0 – 5.3%), with the SRR 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 SRR. Group comparisons of SRR were conducted (sample size permitting) based on the following characteristics: gender, race/ethnicity, sexual orientation, professional status, history of mental health difficulties, and doctoral program accreditation. These categories reflect those which had cell sizes greater than five for examining prevalence of SRR across categories. Group comparisons of categorical variables were conducted using chi-square (χ^2) tests, while group comparisons with dimensional variables were conducted using independent sample *t*-tests.

For the SSD scale items, we ascertained that all items were normally distributed and omitted participants who missed either one of two attention checks ($N = 16$). We also verified that randomization successfully occurred across the vignettes based on age, race, gender, sexual orientation, professional status, and SRRer 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 is likely the identified attitude factors will 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 (MAP) were also examined (Horn, 1965; Velicer, 1976; O'Connor, 2000). Consistent with our preregistered plan, retention of factors and items was considered by inspection of significant ($p < .05$) pattern coefficients ($\geq .30$) and using theory to guide interpretation (Bandalos & Gerster, 2016). The internal consistency of each factor was examined using Cronbach's alpha. 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, Cohen, West, & Aiken, 2014).

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 SRR status (SRR vs. non-SRR) 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 (SRR vs. non-SRR) and participant SRR status (has conducted SRR vs. has not conducted SRR) on attitudes. For Two-tailed tests (alpha of .05) were used 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 partial eta (η^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, such that a Cohen's D of 0.5 means the difference equals half a standard deviation (Lakens, 2013). Partial eta-squared measures the proportion of variance in an outcome that is associated with membership of the grouping variable. An η^2 of 0.10 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. Small, medium, and large effects were determined with Cohen's d values of .15, .36, and .65, respectively. Small, medium, and large effects were determined with η^2 values of .006, .031, and .095, 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 these small effects can have meaningful consequences on outcomes like discrimination (Funder & Ozer, 2019; Lovakov & Agadullina, 2021).

Results

Aim 1a: How common is SRR among psychologists and trainees?

More than one third (33.9%) of respondents reported currently conducting SRR. Just over a fifth (20.7%) reported conducting SRR in the past. Overall, more than half of participants

¹These benchmarks were calculated by converting Lovakov & Agadullina's (2021) Cohen's D values of .15, .36, and .65 into η^2 values using Lakens (2013)'s effect size calculator: <https://osf.io/wgsi3/>

(54.6%) reported *ever* conducting SRR. For brevity, SRRers will refer to participants who endorsed *ever* conducting SRR. Table 1 provides descriptive characteristics of SRRers.

Among SRRers ($N = 905$), over half (52.4%, $N = 474$) of this subsample have pursued SRR on mental health problems when asked about research topic, meaning that over a quarter (27.9%) of the full sample has conducted SRR on mental health difficulties. Likewise, 54.3% said they have conducted SRR on other topics (participants could indicate neither, one, or both of these types of SRR). Most SRRers (81.4%) had a connection to their field of study before starting work in that field, while just 19.9% started a research pursuit *and then* developed a personal connection. Of the SRRers 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 SRRers 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, over half had engaged in SRR, and over one-quarter had engaged in SRR on mental health topics, most of whom had a connection to their topic prior to engaging in its study and whose connection to the topic is driven by their own lived experiences.

Aim 1b: Who conducts SRR among psychologists and trainees?

Rates of conducting SRR were similar across graduate students (57.2%), postdoctoral fellows (57.7%), and faculty (55.2%), while significantly lower rates of SRR 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 SRR compared

to postdoctoral fellows (28.8%), faculty (32.0%), and clinicians (2.3%), $\chi^2 (8, N = 1,708) = 86.21, p < .001$. Experience with SRR 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* SRRers relative to Scientist-Practitioner (35.8%) and Practitioner-Scholar (21.6%) programs, $\chi^2 (6, N = 1,628) = 34.34, p < .001$. See supplementary material for a table displaying the professional characteristics of SRRers.

Rates of SRR did not differ between psychologists and trainees who identified as cisgender men (54.1%) and cisgender women (54.3%), $\chi^2 (1, N = 1,672) = .004, p = .95$. While rates of SRR were also high (79%) among non-binary, transgender, and participants reporting “other” for gender, statistical comparisons were not conducted due to small sample size ($n = 33$). However, SRR 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 SRR than heterosexual/straight participants (50.4%). SRR was also more common among psychologists and trainees from minoritized racial/ethnic backgrounds (63.3%) compared to 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 SRR at some point compared to people without a history of mental health difficulties (35.1%), $\chi^2 (1, N = 1,684) = 57.28, p < .001$. Rates of *current* SRR were also higher among psychologists and trainees with a history of mental health difficulties (37.8%) compared to 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 SRR.

Aim 2: Do psychologists and trainees discredit SRR more than non-SRR?

Prior to 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 SRR, capturing perceptions that SRR is associated with “bias,” “selfishness,” “lack of responsibility,” “bad judgment,” and the SRRer “should pursue a different topic.” Factor 2 represents *strengths-based (positive) attitudes* about SRR, including perceptions that someone who conducts SRR is “admirable,” “insightful,” “motivated,” “serves as a good role model,” and “should be accepted by the academic community.” Factor 3 represents *disclosure views* about SRR, 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* (α range = .77 - .83), *strengths-based attitudes* (α range = .67 - .78), and *disclosure views* (α range = .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.

Supplement table 2 presents means and standard deviations across vignettes. All subscales

²When using parallel analysis, considering eigenvalues exceeding 1.0, and visually inspecting the scree plot, a three-factor solution was supported. However, minimum average partials (MAP) supported a two-factor solution. We proceeded with the three-factor solution because it is consistent with our theorized three-factor solution and because three of four methods (including our pre-registered methods) provided support for this solution.”

correlated with one another across vignettes: factor 1 and 2 (r range: $-.54$ to $-.71$), factor 1 and 3 (r range: $.22$ to $.35$), and factor 2 and 3 (r range: $-.17$ to $-.34$). See supplement for details.

To investigate attitudes about SRR, a series of one-way ANOVAs examined the effect of SRR (SRR vs. non-SRR) on stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales. Psychologists and trainees endorsed more stigmatizing attitudes for hypothetical SRRers ($M = 2.13$, $SD = .60$) more than a hypothetical non-SRRer ($M = 1.91$, $SD = .54$), $F(1, 1774) = 40.18$, $p < .001$, with a small to medium effect size ($d = .38$, 95% CI $[.26, .49]$). In other words, psychologists rated hypothetical SRRers as more biased, selfish, and having bad judgments than a hypothetical non-SRRer.

Psychologists and trainees also disapproved of disclosing SRR ($M = 2.68$, $SD = .71$) across contexts more than non-SRR ($M = 2.14$, $SD = .74$), $F(1, 1774) = 162.83$, $p < .001$, with a large effect size ($d = .76$, 95% CI $[.64, .88]$); this means that psychologists and trainees viewed disclosure of SRR (i.e., disclosing one's reason for interest in a research area) as more inappropriate in settings like a personal statement, job talk, and/or research conference.

Conversely, psychologists and trainees rated a hypothetical SRRer ($M = 3.99$, $SD = .50$) with higher scores on the *strengths-based attitudes* subscale than a hypothetical non-SRRer ($M = 3.63$, $SD = .42$), $F(1, 1774) = 154.80$, $p < .001$, with a large effect size ($d = .74$, 95% CI $[.64, .88]$), meaning SRRers were regarded as more admirable, motivated, and insightful. In sum, hypothetical SRRers were stigmatized at higher levels, but these researchers were viewed as having more positive attributes compared to a non-SRRer.

Aim 3a: Do psychologists and trainees stigmatize SRR on mental health topics more than physical health topics?

A series of one-way ANOVAs compared the effect of SRR on mental health topics (i.e., collapsing vignettes on suicide, schizophrenia, depression, $N = 1,070$) to SRR 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 SRRer on mental health topics ($M = 2.17$, $SD = .61$) more than a hypothetical SRRer on physical health topics ($M = 2.02$, $SD = .54$), with small to medium effects ($d = .24$, 95% CI [.12, .36]). On the disclosure views subscale, psychologists and trainees viewed disclosure of SRR on mental health topics ($M = 2.79$, $SD = .69$) more negatively than disclosure of SRR on physical health topics ($M = 2.33$, $SD = .64$), $p < .001$, with medium to large effects ($d = .68$, 95% CI [.56, .81]). Lastly, psychologists and trainees endorsed positive attitudes on the strengths-based attitudes subscale for a hypothetical SRRer on physical health topics ($M = 4.07$, $SD = .46$) more than a hypothetical SRRer on mental health topics ($M = 3.96$, $SD = .51$), with small effects ($d = .23$, 95% CI [.10, .35]).

Aim 3b: Are certain SRR topics more stigmatized than other SRR topics?

While we found evidence that psychologists and trainees generally viewed SRR on mental health topics more negatively than SRR on physical health topics, we also wondered how attitudes varied by specific SRR topic. A series of one-way ANOVAs examined the effect of SRR topic (e.g., suicide, schizophrenia, depression, cancer) on each SSD subscale (Table 4). All ANOVAS were significant for the omnibus F tests, $ps < .001$ (see for details: <https://osf.io/qw8rv/>), with small to large effect sizes of vignette type on each subscale: stigmatizing attitudes ($d = .25$, 95% CI [.13, .37]), strengths-based attitudes ($d = .22$, 95% CI [.11, .35]), disclosure views ($d = .69$, 95% CI [.57, .82]). We conducted Games-Howell post-hoc

tests to examine mean differences across vignettes because Levene's test suggested violations of homogeneity of variance for each ANOVA.

Psychologists and trainees stigmatized a hypothetical SRRer on suicide ($M = 2.27$; $SD = .65$) significantly more than hypothetical SRRers on depression ($M = 2.06$, $SD = .57$, $p < .001$) and cancer ($M = 2.02$, $SD = .54$, $p < .001$), respectively. Psychologists and trainees also stigmatized a hypothetical SRRer on schizophrenia ($M = 2.18$, $SD = .60$) significantly more than hypothetical SRRers on depression ($p = .023$) and cancer ($p = .001$), respectively. However, participants did not stigmatize a hypothetical SRRer on depression significantly more than a hypothetical SRRer on cancer ($p = .843$). Thus, while psychologists and trainees generally held the most negative attitudes toward mental health topics, such as SRR on suicide and SRR on schizophrenia, psychologists and trainees did not differ in stigmatizing attitudes for SRR on depression versus SSR on cancer, suggesting stigma toward SRR also varies by research topic.

Paralleling findings on the *stigmatizing attitudes* scale, psychologists and trainees viewed disclosure of SRR on suicide ($M = 2.94$, $SD = .70$) more negatively than disclosure of all other topics, including SRR on schizophrenia ($M = 2.65$, $SD = .67$, $p < .001$), depression ($M = 2.80$, $SD = .68$, $p = .027$), and cancer ($M = 2.33$, $SD = .64$, $p < .001$). Similarly, SRR on schizophrenia was perceived more negatively to disclose than SRR on cancer ($p < .001$). Finally, although psychologists and trainees viewed SRR on depression less negatively than SRR on schizophrenia on the *stigmatizing attitudes* scale, and with no differences to SRR on cancer research (see above), psychologists and trainees viewed disclosure of SRR on depression *more* negatively than SRR on schizophrenia ($p = .017$) and cancer ($p < .001$).

Psychologists and trainees also endorsed positive attitudes (i.e., on *strengths-based attitudes*) for a hypothetical SRRer on cancer ($M = 4.07$, $SD = .46$) more than a SRRer on suicide

($M = 3.95$, $SD = .52$, $p = .009$), schizophrenia ($M = 3.96$, $SD = .51$, $p = .017$), and depression ($M = 3.96$, $SD = .51$, $p = .011$). No significant differences of SRR across mental health topics were observed for *strengths-based attitudes* ($ps > .05$). Overall, SRR on mental health topics was more stigmatized, appraised with fewer positive attributes, and viewed as more inappropriate to disclose compared to physical health topics.

Aim 4 (exploratory): Do SRRers discredit other SRRers?

A two-way ANOVA examined the effect of vignette type (SRR vs. non-SRR) and the participants' SRR experience (has conducted SRR vs. has not conducted SRR) on stigmatizing attitudes, strengths-based attitudes, and disclosure views. First, there was an interaction between vignette type and SRR experience on the stigmatizing attitudes subscale, $F(3, 1,679) = 18.00$, $p < .001$, $\eta^2 = .011$. While SRRers ($M = 1.91$, $SD = .54$) and non-SRRers ($M = 1.88$, $SD = .55$) did not differ on stigmatizing attitudes for the non-SRR coping skills vignette, SRRers were less likely to stigmatize ($M = 2.00$, $SD = .55$) a hypothetical SRRer than non-SRRers ($M = 2.28$, $SD = .62$), $\eta^2 = .007$.

There was also an interaction with a small effect size between vignette type and SRR experience on strengths-based attitudes, $F(3, 1,679) = 7.38$, $p = .007$, $\eta^2 = .004$. While there were no group differences on strengths perceptions of the non-SRR vignette (SRRers: $M = 3.63$, $SD = .43$; Non-SRRers: $M = 3.62$, $SD = .43$), the SRR vignettes were viewed more positively by those who have conducted SRR ($M = 4.07$, $SD = .49$) when compared to people who have never conducted SRR ($M = 3.90$, $SD = .49$), $\eta^2 = .006$. There was no interaction between vignette type and SRR experience on disclosure views, $F(3, 1,679) = 1.93$, $p = .165$, $\eta^2 = .001$. Thus, SRRers held fewer stigmatizing attitudes about SRR than people who had never conducted SRR, and SRRers viewed other SRRers as having more positive attributes.

Discussion

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

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

Some caveats to these findings should be noted. While these results validate concerns that disclosing a personal connection to one's research is viewed negatively in comparison to non-SRR (Linehan, 2020; Carey, 2011a; Harris, 2021), the means on the stigmatizing attitudes subscale were below the mid-point across SRR vignettes, indicating that overall attitudes were not disapproving of SRR. This response pattern is typical for research on stigma and prejudice (Campbell & Brauer, 2021; Wood et al., 2014).

It appears, then, that SRRers face somewhat of a precarious situation—they may be more admired or castigated depending on the context, which accords with indications that some

perspectives discourage SRR disclosure (e.g., “Mitch’s Uncensored Guide...”; Prinstein et al., 2017) and others encourage it (Devendorf, 2020b; Salzer, 2021; Victor et al., 2020). This suggests there are risks and rewards in 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 in what level of personal detail (Kang et al., 2016). We suspect that SRR disclosure varies by context, domain of research, and other aspects of one’s identity and position within the field (Salzer, 2021; Rüsch, N., & Kösters, 2021), but future research should clarify these relationships.

Our study did find evidence that acceptance of SRR depends on the research topic. We confess it was discouraging to find support for our hypotheses that psychologists stigmatize SRR on mental health difficulties, such as suicide, depression, or schizophrenia, to a greater extent than physical health conditions like 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 et al., 2022b). Our findings indicate that the pursuit of SRR on suicide and schizophrenia are more stigmatized than SRR on depression and cancer, and disclosure of all mental health topics were viewed as more inappropriate than disclosure of SRR on cancer. It is possible that these findings are at least partially explained by population prejudice toward mental illness relative to physical illness (Teachman et al., 2006; Link & Phelan, 2013).

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 there exists a tension between psychologists stated values and mission (APA, 2011) – to be effective mental health advocates – when we, ourselves, hold negative judgements about mental illness. Our data speak to the need for intentional advocacy and anti-stigma efforts from 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 SRR and psychopathology in diversity, equity, and inclusion (DEI) efforts (see for recommendations, Victor et al., 2022b).

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

While faculty and students had similar rates of *ever* conducting SRR, graduate students were more likely to be conducting SRR when they completed the survey. Our data cannot definitively explain this faculty and student discrepancy, but we propose some possible explanations. First, it is possible that personal experience draws people into psychology research, but whether they continue to pursue SRR is influenced by other factors. Perhaps research

interests simply change over time or the opportunity to conduct SRR 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 SRR have shifted over time, leading to cohort effects whereby current students are more likely to engage in SRR relative to more established members of the field (Brown & Patterson, 2021; Shepherd et al., 2021). Another possibility is that SRR is more stigmatized and less accepted in the academic community, which leads SRRers to be selected out of the field prior to engaging in research as faculty.

This study provides the first assessment of SRR and attitudes in a large, representative dataset of psychology faculty and trainees from accredited North American programs. The measurement of SRR was optimized by having participants respond to an operationalized definition of SRR, and our vignette approach allowed us to experimentally compare attitudes about SRR by self-relevant status and across several research topics. We developed the “Stigma, Strengths, and Disclosure (SSD) Scale for SRR” to assess a multitude of attitudes about SRR 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 others 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 other studies with overlapping aims

(Tay et al., 2018), and care was taken in study advertising to avoid oversampling of people who conduct SRR, the relative proportion of eligible individuals who completed the survey is a limitation. Our study also only targeted 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. While we assessed a spectrum of attitudes and by stereotypes by developing the SSD scale, we regret not incorporating specific items that capture perceived “credibility” and “trustworthiness” of SRR for comparison to other published work (Altenmüller et al., 2021). The SSD only captures attitudes about SRR, rather than behaviors enacted towards individuals who engage in SRR. We advise future researchers to develop behavioral approaches to assess and capture the possibility of more serious discriminatory actions taken toward SRRers (e.g., rejection from graduate school, a job, or scholarship). The experimental vignettes were also not counter-balanced by research topic and SRR, 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 to proxy research on physical health topics. These decisions were made to balance concerns about obtaining adequate sample size across conditions while ensuring a rich data collection for this first investigation. Given that we found variability in attitudes toward SRR on mental health topics, we hope future studies will explore how SRR 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 SRR. We hope these data will foster needed conversations about the status quo of accepting (or not) SRR on mental illness topics. Our work should spark greater efforts to better understand how to cultivate inclusion – rather than exclusion – of SRRs in psychology. We highlight five takeaways from our findings and recommend areas to guide future investigation.

1. Disclosure of SRR has risks and rewards. While over half of psychology and trainees have conducted SRR, our data suggest that SRRers should weigh the risks when deciding to disclose a personal connection to a research topic. SRRers who study mental illness topics such as suicide, schizophrenia, and depression may be especially prone to being 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 others' 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 SRR and/or mental illness disclosures.

Even if these prejudices are only held by 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 SRR 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 manuscript to recommend whether to disclose, or how to disclose, but we hope that future discussions will advance guidance and mentorship on effective disclosure, such as through efforts like the Honest, Open, and Proud Program (Rüsch & Kösters, 2021; Kundert & Corrigan, 2021).

2. Investigate and address the causes of stigma toward SRR. One important focus for future work should be to investigate the causes of biases against SRR. One possibility in clinical psychology is that stereotypes about SRR manifest before students even enter graduate school, when students are warned that applicants are “often screened out” for disclosing their own psychopathology (Prinstein, 2017, p. 24). 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 judgements continue to persist.

3. Accepting SRRers connects to diversity and inclusion efforts in psychological science. We found that members of minoritized backgrounds—including members of LGB sexual orientations, non-white racial/ethnic groups, and individuals with a history of mental health difficulties—were more likely to conduct SRR compared to the majority members. When considering that psychology has continued to struggle to gain adequate representation of these marginalized backgrounds in research (Callahan et al., 2018; Dimmick & Callahan, 2021; Miller & Orsillo, 2020), it becomes crucial that psychologists not also discriminate against someone for their personal motivations to pursue research. Along these lines, while this study has primarily

discussed SRR on mental illness, we hope our arguments are also considered in the context of SRR on non-mental 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; Harris, 2021). Future research might consider how anti-SRR bias depends on both professional context and the SRR identity. For example, how do attitudes about SRR vary among medical, social work, and nursing professionals?

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

5. What are the strengths and challenges to conducting SRR, and how do SRRers navigate their path? Our study only speaks to *beliefs* about SRRers, but a worthwhile direction is to investigate the *experienced* benefits and challenges encountered when conducting SRR. One fruitful research question regards how to facilitate the end goal of helping SRRers explore their strengths and challenges of their lived experiences. Put otherwise, what are strategies that SRRers 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 SRRer on non-suicidal self-injury and an author on this paper, serves as one example for how we might understand how SRRers 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).

Conclusion

SRR 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, 2020a). We have argued and documented evidence that real prejudice exists toward SRR, when compared to non-SRR, which has strong repercussions for not just our field, but for individuals who conduct SRR. We have shown that SRR is not uncommon or insubstantial in psychology; over half of applied psychologists and trainees have conducted SRR, and about one-third actively conduct SRR. This data substantiates the importance of including SRR 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 SRR is “better” or “should be the norm” in psychology. Rather, we believe these data indicate that the field needs to have a deeper reckoning with SRR, and with the acceptability of SRR and SRRers.

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

	SRRer <i>N</i> (%)	Non-SRRer <i>N</i> (%)	Full Sample <i>N</i> (%)
Gender			
Cisgender woman	713 (77.2)	605 (78.8)	1393 (78.1)
Cisgender man	184 (19.9)	156 (20.3)	358 (20.1)
Non-binary / gender non-conforming	18 (2.0)	6 (78.8)	24 (1.3)
Other	5 (.5)	0 (0)	5 (.3)
Transgender man	2 (.2)	1 (.1)	3 (.2)
Transgender woman	1 (.1)	0 (0)	1 (.1)
Race/Ethnicity			
Non-Hispanic white	756 (81.7)	658 (85.6)	1490 (83.3)
Hispanic / Latinx	84 (9.1)	43 (5.6)	135 (7.6)
Multiracial / Biracial / Other	18 (1.9)	5 (.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 (.3)	1 (.1)	4 (.2)
Sexual Orientation			
Heterosexual / straight	665 (72.6)	658 (86.5)	1394 (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 (.9)	43 (2.4)
Asexual	5 (.5)	3 (.4)	8 (.5)

SRRer = any respondent who endorsed ever conducting SRR.

Table 2. ^aPattern Coefficients and Reliability of the Stigma, Strengths, and Disclosure Scale (SSD) using Promax Rotation with Kaiser Normalization

	Factor 1 Stigmatizing Attitudes						Factor 2 Strengths-based Attitudes						Factor 3 Disclosure Views					
Item	SUI	SCZ	DEP	CAN	COPE	FULL	SUI	SCZ	DEP	CAN	COPE	FULL	SUI	SCZ	DEP	CAN	COPE	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 judgement	.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 alpha	.834	.798	.812	.766	.770	.801	.778	.750	.754	.752	.667	.754	.814	.830	.798	.848	.908	.860

SUI = suicide vignette; SCZ = schizophrenia vignette; DEP = depression vignette; CAN = cancer vignette; COPE = coping skills vignette; FULL = full sample results

Bold = extracted items for each factor; **Cronbach's alpha** = the internal reliability of the bolded items for each factor.

^aExtraction method: principal axis factoring

Table 3. Eigenvalues and Variance Explained for Rotated Factor Solutions of the Stigma, Strengths, and Disclosure Scale (SSD) using Promax Rotation with Kaiser Normalization

	SUI	SCZ	DEP	CAN	COPE	FULL
Factor 1: Stigmatizing Attitudes	EV=5.31 V=35.38%	EV=4.86 V=32.57%	EV=4.97 V=33.15%	EV=1.34 V=8.93%	EV=2.83 V=18.89%	EV=2.63 V=17.50%
Factor 2: Strengths-based Attitudes	EV=1.18 V=7.89%	EV=1.16 V=7.71%	EV=1.31 V=8.73%	EV=2.58 V=17.19%	EV=1.40 V=9.35%	EV=1.48 V=9.86%
Factor 3: Disclosure Views	EV=2.29 V=15.27%	EV=2.56 V=17.03%	EV=2.11 V=14.09%	EV=4.61 V=30.74%	EV=4.42 V=29.50%	EV=4.76 V=31.72%
Total Variance Explained	58.45%	57.30%	55.96%	56.86%	57.74%	59.08%

SUI = suicide vignette; SCZ = schizophrenia vignette; DEP = depression vignette; CAN = cancer vignette; COPE = coping skills vignette; FULL = full sample results; EV = eigenvalue; V = variance explained

Table 4. Means and Standard Deviations Across Vignettes ($N = 1,776$)

	Stigmatizing Attitudes	Strengths-based Attitudes	Disclosure Views	Cell Size
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>N</i>
SRR Suicide	2.27 (.65)	3.95 (.52)	2.94 (.70)	352
SRR Schizophrenia	2.18 (.60)	3.96 (.51)	2.65 (.67)	358
SRR Depression	2.06 (.57)	3.96 (.51)	2.80 (.68)	360
SRR Cancer	2.02 (.54)	4.07 (.46)	2.33 (.64)	352
Non-SRR Coping Skills	1.91 (.54)	3.63 (.42)	2.14 (.74)	354

SRR = self-relevant research