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A Qualitative Exploration Of The Lived Experiences Of Graduate Students With Histories Of Mental Health Diagnoses Navigating Clinical Psychology Doctoral Programs

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A QUALITATIVE EXPLORATION OF THE LIVED EXPERIENCES OF GRADUATE STUDENTS WITH HISTORIES OF MENTAL HEALTH DIAGNOSES NAVIGATING CLINICAL PSYCHOLOGY DOCTORAL PROGRAMS

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ABSTRACT

In general, graduate students experience unhealthy stress levels throughout their graduate careers. Clinical psychology doctoral students experience additional stressors related to intensive training in providing psychological-related services to clients. There is a gap in the literature in understanding how clinical psychology doctoral students with a personal history of mental health effectively navigate highly stressful graduate programs. This dissertation explored the experiences of clinical psychology Ph.D. students who 1) have a history of mental health diagnoses and 2) experience current psychological distress as they manage educational/training demands and administer psychological interventions to clients. A phenomenological qualitative approach was utilized to fully capture the essence of participants' lived experiences. Data for the study was collected through individual semi-structured interviews. Transcriptions of the interviews underwent a rigorous coding process to determine the study results. Findings were delivered as overall themes that described the participants' lived experiences. There were five overall themes: Heavy Emotional Experiences, Advisor/Mentor, Disclosure, Unique Relationships with Psychotherapy, and Resiliency. Recommendations for interventions and strategies to support this population are discussed.

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I want to thank my lovely friends, family, and mentors who demonstrated true unconditional love throughout my doctoral graduate career. I would not have made it without your gracious support and care. I am genuinely thankful for you all.

I hope this project provides comfort and solidarity to other graduate students navigating their mental health journey. I hope those involved in graduate students' schooling and life learn something new from this project to support students in their lives better.

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Introduction

The graduate students are not all right.

Graduate students enter their program with a desire to obtain specialized knowledge and become an expert in their chosen field of study. Individuals enrolled in a graduate program are expected to engage in rigorous research and training. Intensive education within a specific domain allows students to obtain specialized knowledge within specific academic disciplines. The graduate student experience of such thorough training appears to come with negative side effects. There has been a rising concern that graduate students experience unhealthy levels of stress.

A growing number of fields have publicly recognized that their graduate students often experience significant distress. Numerous professional associations have called for the implementation of initiatives to improve the mental health of post-undergraduate trainees. In 2004, the Association of American Medical Colleges and the Institute of Medicine submitted a call to action to improve the well-being of medical students (AAMC, 2004; IOM, 2004). In 2013 and 2014, professionals in the fields of nursing, dentistry, and veterinary medicine sounded the alarm on their students experiencing unhealthy stress levels (Elani et al., 2014; Melnyk et al., 2013; Siqueira et al., 2014). Despite these warnings and calls to address the mental well-being of graduate students, research shows that graduate students have continued to report experiencing high levels of distress and symptoms of psychopathology (Burkhart, 2014; Siegel & Keeler, 2019; Woolston, 2019). What about the students from the field of psychology?

Albeit slower than the previously mentioned fields, the field of psychology has more recently responded to said calls for intervention. In 2018, the American Psychological

Association formed a committee to address the treatment of graduate students in psychology and offer potential policies and practices for programs that uphold the "equitable and respectful treatment of graduate students (American Psychological Association & APAGS-BEA Work Group, 2023, p.1). The first guidelines offered by this committee described the need for graduate psychology programs to support the "physical psychological and financial wellness of graduate students," with the caveat that programs do this to the best their resources allow (American Psychological Association & APAGS-BEA Work Group, 2023, p.6). In support for graduate students, their guidelines suggested that students have access to affordable mental health care coverage or be offered other affordable options for services that the program cannot provide (American Psychological Association & APAGS-BEA Work Group, 2023). Such guidelines demonstrate the gravity of the rising mental health crisis within psychology graduate students. This study focused on one subfield of psychology: clinical psychology graduate students.

In the past few years, there has been an increasing interest in clinical psychology graduate students' mental health and well-being as they learn to provide psychotherapy services and psychological assessments (Forrester, 2021). Clinical psychology doctoral students in particular have reported higher rates of mental health concerns over and beyond those found in the general population and those of students in medical school for several years (Rummell, 2015). A growing number of studies have examined clinical psychology graduate students' distress within their academic and clinical work. For example, clinical psychology graduate students are more likely to report being diagnosed with depression than undergraduate students or even the general population (Siegel & Keeler, 2019). In a recent study of 912 clinical psychology graduate students, approximately one-third of participants endorsed having a history of mental health concerns before attending graduate school (Hobaica et al., 2021). The clinical

psychology students clearly have demonstrated a potential susceptibility to develop psychological disorders while in graduate school. However, it is possible that clinical psychology graduate students are entering their programs with a history of a mental health diagnosis.

Clinical psychology students with a history of mental health concerns could be at risk for experiencing a reemergence of said mental health concerns when they navigate a highly stressful environment within their graduate program. These students could face additional stressors related to their history of mental health concerns. This group of students likely has unique experiences of being in graduate school compared to their graduate peers who do not have a history of mental health concerns. It is for such reasons that this study was created.

This study aimed to examine the experiences of clinical psychology graduate students who 1) have a prior history of mental health concerns and 2) are currently experiencing mental health concerns to understand better the resiliency that aids in their progression through intensive clinical training and high academic demands. The findings of this study offer valuable insight into how clinical psychology graduate programs could better support students with a mental health history as they navigate a stressful environment. The literature review will further describe the general expectations of graduate school. Historical and recent research regarding the state of mental health for graduate students will be discussed, emphasizing findings on clinical psychology graduate students. Due to the limited research on the lived experiences of clinical psychology graduate students with a history of mental health concerns, the relevant literature on psychologists' mental health history and the functioning of psychologists is also explored. The results are focused on the lived experiences of clinical psychology students with a history of menteal health struggles who are also navigating the stressful environment that is their graduate

program. The discussion highlights the messages to learn from this study through the self-reflection of the researcher.

Literature Review

Experiences of Graduate Students

There are multiple activities typical graduate students must complete throughout their graduate careers. Graduate studies require extensive time studying field materials, conducting program-required projects (i.e., theses/dissertations), applying for grants, submitting article publications, and teaching undergraduate courses for a graduate stipend. Graduate students typically need to secure the mentorship of program faculty members for research practice and academic teaching goals. Generally, graduate students rely heavily on academic advisors for mentoring throughout the program and letters of recommendation to advance their careers. There can be difficulties that arise during this time.

It is not unusual for graduate students to face academic-related setbacks throughout their graduate careers. Students may struggle to maintain program academic expectations. They could fail required courses, which would require them to retake the course the next time it is available, which could be up to a year or two later. Students could receive poor ratings from their program advisor or a faculty member on official evaluations of competency and professionalism. A significant interpersonal dispute between a graduate student and their faculty advisor could occur. Graduate students might need to find a new program faculty member for guidance when there is a fallout between a graduate student and their faculty advisor. These situations are common occurrences within a graduate-level program; however, these events can cause vast amounts of additional stress for graduate students. Graduate students face additional stressors beyond the innerworkings of their program, however.

Graduate students often face multiple financial stressors, including food and housing insecurity (Coffino et al., 2021). They sacrifice years of professional salary compared to their peers who do not attend graduate school. Furthermore, graduate students typically receive low stipends that make it difficult to pay rent, needed living expenses, and program tuition (Flaherty, 2018). They are additionally burdened with great student loan debt, that only increases throughout their career in higher education. This group has an average of $36k in student loan debt from their undergraduate degree (Hansen, 2021). Master-level graduate students obtain an average of $55k loan debt specifically from graduate school (Hansen, 2021). Students with a Doctor of Philosophy degree typically accumulated an average of $107k in student loan debt. (Hansen, 2021). Meanwhile, entry-level clinical psychologists with one to four years of experience typically earn $70k annually (PayScale, 2021). Approximately 50% of psychologists earn less than $79k annually (US. Bureau of Labor Statistics, 2021). Approximately 75% of psychologists earn less than $104k annually (US Bureau of Labor Statistics, 2021). Only 10% of psychologists earn more than $138k annually (US. Bureau of Labor Statistics, 2021). In sum, graduate students face massive debt from their undergraduate, master's, and doctoral degrees, while their salary as psychologists likely will not be more than the debt they have accumulated.

Amid such stressors, it is important to recognize that individuals enter graduate school with their own life experiences, which could aid in experiencing additional stressors. There is no known research currently suggests that the cause of graduate students developing mental health disorders is due to graduate school. However, it is well known that psychological disorders can be triggered or developed through environmental-related stressors and graduate school is arguably described as a stress inducing environment. Regardless, research has documented that

graduate schools do, in fact, endorse experiencing psychological disorders and clinically significant stress.

Mental Health of Graduate Students

Graduate students across various disciplines have reported experiencing moderate to severe mood disturbances symptoms at higher rates than the general adult population. Multiple studies have quantitatively examined graduate students' mental health. One study surveyed the mental health of first-year health science graduate students (*N*=93) (Melnyk et al., 2016). Another study examined 2279 graduate students from 234 institutions and many fields of study, including biology, physical sciences, engineering, humanities, and social sciences (Evans et al., 2018). Of these two studies, approximately 39-41% of graduate students reported recently experiencing moderate to severe symptoms of depression, compared to the general population where approximately five percent of adults endorse experiencing moderate to severe depression. (Evans et al., 2018; Kroenke et al., 2001; Melnyk et al., 2016). In addition, approximately 28-41% of graduate students from these studies recently experienced moderate to severe anxiety symptoms compared to another five percent of adults from the general population who endorsed experiencing a moderate to severe presentation of anxiety symptomology (Evans et al., 2018; Löwe, 2008; Melnyk et al., 2016). Additionally, approximately four percent of graduate students reported experiencing suicidal ideation (Melnyk et al., 2016). Graduate students across multiple disciplines have historically endorsed experiencing suicidal ideation, suicide planning, and non-suicidal self-injury (Bramness et al., 1991; Clark, 2019; Jafari et al., 2012). Beyond clinical presentations of mental health, graduate students have reported on stressors they experience from the innerworkings of their program.

Graduate students have described feeling exhausted from the course load (Siegel & Keeler, 2019). They have reported that they are expected to "struggle" (i.e., experience high levels of stress) in graduate school, lest they be evaluated as underperforming compared to their peers (Siegel & Keeler, 2019, p.213). Those in this group who are experiencing significant depressive symptoms believe they should experience such distress because it indicates the effort they have contributed to their studies (Siegel & Keeler, 2019). Graduate students may also experience significant psychological symptoms and believe that all their peers experience these symptoms as well (Siegel & Keeler, 2019). In other words, many students believe it is either normal to experience unhealthy levels of stress and distress or that they are not living up to the expectations of graduate study.

Many graduate students perceived this "mental exhaustion" they experience from chronic lack of sleep and excessively long work hours as something to boast about (Siegel & Keeler, 2019, p. 213). Graduate students who recognized that they were experiencing clinical depressive symptoms believed they needed to hide their symptomology from their program faculty (Siegel & Keeler, 2019). They described that they would feel "horrified" if it was revealed to their faculty that they were experiencing depression for fear of potential professional repercussions (Siegel & Keeler, 2019, p. 214).

Graduate students described experiencing a "culture of silence" regarding mental health concerns while enrolled in a graduate program (Siegel & Keeler, 2019, p. 213). In addition, graduate students have reported not hearing faculty or other institutional figures describing their mental health struggles (Siegel & Keeler, 2019). Often, graduate students fear potential negative judgment from program faculty and advisors that could negatively impact their careers (Siegel & Keeler, 2019). Clearly some graduate students endorse experiencing concern related to stigma

about being open about their mental health struggles. Some graduate programs have attempted to address this culture of silence through events that specifically counter being silent about mental health experiences.

Out of concern for their medical students not seeking help due to stigma, one school of medicine started a mental health initiative to decrease stigma (Brenner et al., 2023). In 2015-2016 it hosted all school events where faculty and peers shared stories focusing on mental health and experiences with failure (Brenner et al., 2023). Attendees reported that the experience worked to destigmatize mental illness and making mistakes. There was a reported increased use of medical students utilizing on-campus student counseling services from 8% of medical students in 20214-2015 compared to 19% for 2018-2019 and 33% for 2020 (Brenner et al., 2023).

Another medical training program hypothesized that faculty self-disclosure about personal experiences with mental health may reduce the stigma for students to seek out mental health treatment while in training (Vaa Stelling & West, 2021). At an internal program conference, three medical faculty members shared their personal mental health experiences with medical residents (Vaa Stelling & West, 2021). Approximately 85% of the attendees reported they were more likely to seek mental health resources following the conference (Vaa Stelling & West, 2021). Approximately 98% of the attendees endorsed feeling that the experience worked to destigmatize mental health issues that arose during the training process (Vaa Stelling & West, 2021). These initiatives appeared to be successful in breaking down barriers for graduate students to potentially discuss mental health experiences within their program and reach out for mental health support.

The following section will focus specifically on clinical psychology doctoral graduate students' experiences within their programs, and their mental health.

Mental Health of Clinical Psychology Graduate Students

Clinical psychology doctoral students hold unique experiences and expectations. This group typically devotes at least five years to completing their Ph.D. Students are heavily trained in psychology-related research, assessment, and psychotherapy throughout their graduate careers. Clinical psychology doctoral students receive frequent, formal evaluations by program faculty. They are evaluated on completing coursework, passing comprehensive exams, and progressing toward intensive research projects. These students are evaluated on their engagement in professionally relevant activities. They are expected to exhibit an understanding of ethics and demonstrate professional attitudes and beliefs. This group must additionally upload expectations related to the clinical work.

Clinical psychology doctoral students are expected to develop strong clinical skills to assess clients for psychopathology and functioning; this is completed through several ways. They must demonstrate competencies in administering empirically supported treatments. Clinical psychology doctoral students engage in weekly individual and group clinical supervision to meet these clinical expectations. They typically maintain a caseload within their program clinic and participate in training opportunities at affiliated local sites (i.e., community mental health centers, private outpatient practices, university counseling centers, etc.). For the last year of training, clinical psychology doctoral students are expected to compete nationally for an outside internship experience (akin to the residency year of medical training) to receive advanced training in clinical practices. The general and clinical expectations of a clinical psychology graduate program can be very stressful. However, such stress from a clinical psychology graduate program can start before the official acceptance into such a program, especially for

potential students who have a history of mental health struggles prior to attending a graduate program.

The application process for clinical psychology graduate programs can be confusing for potential incoming students who have already had lived mental health experiences. When surveyed, approximately one-third of clinical psychology doctoral students reported having a history of mental health concerns before entering graduate school (Hobaica et al., 2021). This group faces unique circumstances regarding potentially disclosing personal experience in their application materials. Mitch's Uncensored Advice for Applying to Graduate School in Clinical Psychology, a popular and widely recommended free 'how to' document on applying to clinical psychology graduate programs, does not offer explicit advice on self-disclosure regarding personal or family mental health experiences in application materials. However, the document links to another self-help document made by one of his students, which recommended not to "disclose sensitive or inappropriately personal information (e.g., your own diagnoses)" (Choukas-Bradley, 2011, p.17).

Another provided self-help document from Mitch's document reports that applicants should be as personal as they feel comfortable to do (Mote, 2021). However, it makes the warning that individuals reviewing applications can be biased and have their own stigmatized mental health views (Mote, 2021); however, this writer also does mention having read strong essays from applicants about their experiences with family mental health events and personal disabilities (Mote, 2021). These documents ultimately leave the final call up to the reader; however, it sets the stage for the sort of stigma from graduate school that students can expect related to experiencing mental health struggles.

Other such example of stigma of student mental health comes from program application reviewers. Psychology chairs of graduate admissions committees provided examples in personal statements that led to the rejection of strong applications (Appleby & Appleby, 2006). Disclosure of personal mental health in personal statements was one such example, with one chair commenting that "graduate school is an academic/career path, not a personal treatment or intervention for problems" (Appleby & Appleby, 2006, p.20). The idea of potential students being drawn to a field because of their own or family's mental health experiences was seen as less pure or less objective in the quest to learn more about science (Appleby & Appleby, 2006). Chairs also showed concern that the applicant would not function well in grad school due to their experiences with mental health (Appleby & Appleby, 2006). Applicants were also deemed negatively if they were perceived as engaging in excessive self-disclosure; this was seen as potentially a demonstration of poor interpersonal boundaries. Before even entering graduate school (if they make it in), students are potentially facing discrimination based on their mental health experiences. What about the students with lived experiences of mental health who make it through the application process and become a clinical psychology doctoral student?

Then comes the actual journey through a clinical psychology doctoral program, which has been noted to be particularly stressful for graduate students. In 2021, approximately 900 clinical psychology doctoral students were surveyed regarding their experiences with personal mental health concerns (Hobaica et al., 2021). Students reported experiencing psychopathology throughout their graduate careers (Hobaica et al., 2021). Of the clinical psychology doctoral students who experienced mental health concerns throughout their career, 25% endorsed experiencing moderate to severe symptoms of anxiety, 25% endorsed experiencing moderate to

severe symptoms of depression or suicidal intent, and 10% endorsed engaging in high-risk behaviors related to alcohol or drug use (Hobaica et al., 2021).

Clinical psychology graduate students additionally endorsed experiencing greater rates of suicidal ideation, suicide planning, and non-suicidal self-injury compared to graduate peers from other disciplines and the general population (Hobaica et al., 2021). For instance, approximately 17% of clinical psychology graduate students reported that they had experienced suicidal ideation; approximately seven percent of graduate students from other disciplines and 2% of the general population reported experiencing suicidal ideation (Hobaica et al., 2021; Garcia-Williams et al., 2014). Approximately four percent of clinical psychology graduate students experienced suicidal planning, while approximately 2% of graduate students from other disciplines and 0.6 % of the general population reported experiencing suicidal planning (Hobaica et al., 2021; Garcia-Williams et al., 2014). Approximately six percent of clinical psychology graduate students endorsed experiencing non-suicidal self-injury; meanwhile, approximately two percent of graduate students from other disciplines and one percent of the general population reported experiencing non-suicidal self-injury (Garcia-Williams et al., 2014; Hobaica et al., 2021).

Clinical psychology graduate students who experienced mental health struggles before entering graduate school were seven times more likely to experience non-suicidal self-injury, four times more likely to experience suicidal ideation, and nine times more likely to endorse having a suicide plan compared to their clinical psychology graduate peers who did not experience mental health struggles before entering graduate school (Hobaica et al., 2021). It is of the utmost importance to increase awareness and support for this population, given their high suicide risk.

Mental health experiences of clinical psychology doctoral students are found beyond the United States. Across 19 United Kingdom training institutions, 67% (*N*=348) of students training to become clinical psychologists reported having either experienced or were currently experiencing mental health issues (Grice et al., 2018). Some of the mental health experiences that students endorsed experiencing included anxiety (43%), depression (39%), social phobia (16%), an eating disorder (14%), specific phobia (12%), panic disorder (11%), PTSD (6%), obsessive-compulsive disorder (5%), drug/alcohol dependence (5%), adjustment disorder (4%), and once-off psychotic episode (2%) (Grice et al., 2018). Clinical psychology doctoral students with both histories of mental health experiences and recent mental health struggles exist within programs. What can be some consequences for existing within the space of a clinical psychology doctoral program?

There can be many consequences clinical psychology doctoral students may face in programs if they continue to exhibit psychopathology. Historically, psychology graduate students have been dismissed from programs for having a "personality disorder" and "emotional problems" (Tedesco, 1982; Vacha-Haase, 1995). One factor protecting this group is the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct code 7.04 Student Disclosure of Personal Information, which states that students are not required to disclose personal information in program-related activities, including psychological treatment experiences (American Psychological Association, 2017). However, exceptions to this include if the program has a preexisting requirement for the students to disclose such information, as reflected in the training program's training materials (American Psychological Association, 2017). Another exception would be if a student's personal problems were perceived as impeding their performance in their training or other professional activities or deemed a threat to students

or others (American Psychological Association, 2017). So, the American Psychological Association's ethical standards are ultimately left to program discretion when it comes to requiring student self-disclosure for personal issues, which have, in one of the worst-case scenarios, led to students being forced to leave their programs.

Clearly, students come into clinical psychology graduate programs with histories of lived mental health experiences. They then enter a stressful environment, which can exacerbate or lead to the rising of new psychopathology. Research appears to demonstrate that clinical psychology doctoral students experience psychopathology at rates higher than other graduate students and the general population. If students face academic impairment due to their mental health struggles, their programs may choose to dismiss the student.

The next section examines the additional struggles and experiences of clinical psychology graduate students who hold minoritized identities.

Considerations for Students with Minoritized Identities

Examining the existing literature on the mental health experiences of clinical psychology graduate students with minoritized identities is crucial. Individuals from minoritized communities are at risk for mental health concerns due to social, historical, and contemporary stressors, which may manifest in minority stress and intergenerational trauma (Lehrner & Yehuda, 2018; Meyer, 2003). The recent Black Lives Matter movement, protests against the oil pipeline installation on indigenous land, and demands for immigration reform in the United States of America show unique stressors experienced by Black, Indigenous, and other racially/ethnically minoritized individuals. Outside stressors faced by this population were discussed. Further examination of stressors for this group that may occur within a doctoral program will be explored next.

There are documented experiences of discrimination and prejudice against graduate students from minoritized groups such as Black, Indigenous, and other persons of color (BIPOC) and lesbian, gay, bisexual, transgender, and queer (LGBTQ+) students. In a survey of over 6,000 doctoral-level students, 21% of students endorsed experiencing discrimination or harassment in their program (Woolston, 2019). Of this 21%, 39% of students reported experiencing gender discrimination, and 33% of students reported experiencing racial discrimination or harassment (Woolston, 2019). Additionally, 16% of students reported experiencing age discrimination, 15% of students reported experiencing sexual harassment, and 9% of students reported experiencing religious discrimination (Woolston, 2019). Lastly, 4% of students reported experiencing disability discrimination, and 3% of students reported experiencing discrimination or harassment as LGBTQ+ students (Woolston, 2019). When asked about bullying, 21% of students endorsed experiencing bullying within their programs. The most common perpetrators of discrimination or harassment were reported as being supervisors (48%) and other students (38%) (Woolston, 2019). Minoritized students clearly experience additional stressors compared to their peer students. Next, let us further examine BIPOC and LGBTQ+ experiences with mental health in doctoral programs.

Notably, clinical psychology doctoral students who hold minoritized identities, such as LGBTQ+ and BIPOC individuals, recently reported experiencing higher rates of mental health concerns compared to their peers (Hobaica et al., 2021). Clinical psychology doctoral students with minoritized ethnic and racial identities experienced a higher severity of depressive symptoms than their White colleagues (Hobaica et al., 2021). Significantly more racial/ethnic minoritized students experienced depressive symptoms when compared to their White peers (Hobaica, 2021). Clinical psychology doctoral students who identified within the LGBTQ+

community endorsed greater depressive symptoms, substance use, non-suicidal self-injury, and suicidal ideation than their non-LGBTQ+ colleagues (Hobaica et al., 2021). Interestingly, White students engaged in significantly greater alcohol use than their racial/ethnic minoritized peers (Hobaica, 2021). BIPOC and LGBTQ+ students clearly face additional unique stressors compared to their peers. It is important to consider this populations unique stressors moving forward.

Summary

Historically, it has been widely accepted (and expected) that graduate students experience stress throughout their graduate career. More recently, attention has been given to the unhealthy amounts of stress experienced by graduate students. Graduate students in all fields have endorsed experiencing moderate to severe symptoms of depression and anxiety (Evans et al., 2018). Some graduate students have reported that they must conceal their psychopathology experiences from program faculty to protect themselves from professional repercussions (Siegel & Keeler, 2019). Clinical psychology graduate students, particularly individuals who have minoritized identities, have reported experiencing higher rates of depression and anxiety symptoms compared to other graduate students and the general population (Hobaica et al., 2021). Graduate students, particularly clinical psychology doctoral individuals with minoritized identities, need greater support to manage graduate-related stressful experiences.

Self-Care

As has been demonstrated, graduate students face unique stressors and can experience psychopathology while in graduate school. One of the coping strategies thought of to aid graduate students is for them to engage in self-care activities. Self-care is the practice of attending to the person's own physical, mental, and spiritual well-being. Acts of self-care include

practicing good sleep hygiene, engaging in physical activity, participating in a hobby, and spending time with friends and family. There can be many benefits of self-care.

Specifically, self-care is thought to prevent graduate student impairment and poor functioning. The American Psychological Association (APA) has encouraged psychology students and psychologists to engage in self-care as they navigate highly stressful work environments (Baker, 2003; Dearing et al., 2005; Gilroy et al., 2002). As such, self-care is among the professional development competencies that are required to be achieved in an APA-accredited doctoral training programs in clinical psychology. Interestingly, graduate program faculty have reported to believe that self-care was vital for clinical psychology graduate students to manage the stress from being in a very demanding environment (Burkhart, 2014). On the same side, it has been posited that clinical psychology graduate students do not participate in enough self-care to protect themselves against the harmful effects of experiencing increased stress within the graduate school environment (Burkhart, 2014). Self-care is a top priority within graduate school; however, what does the research say about graduate students and self-care?

Despite this, there is little research on how graduate students achieve a healthy level of self-care within clinical psychology doctoral programs, especially given this population's unique barriers to accessing mental health treatment (Rummell, 2015). Given graduate students' high academic and performance demands, increased levels of unhealthy stress, and the prevalence of a personal mental health history, it is arguably to be expected that this population would continue to experience stress in their professional careers as psychologists.

The next section discusses the documented mental health experiences of psychologists.

Mental Health of Psychologists

A popular misconception describes psychologists as 1) having an absence of personal mental health history and 2) never experiencing mental health struggles while providing psychological services (Cain, 2000; Knaak et al., 2017; Zerubavel & Wright, 2012). Despite this, many prominent psychologists have revealed that they experienced chronic, severe mental health illnesses later in their careers. One such psychologist is Marsha Linehan, the founder of dialectical behavior therapy, which is a helpful treatment for individuals living with borderline personality disorder (Stoffers-Winterling, 2020). Linehan has discussed experiencing borderline personality disorder herself and how she continues healing herself and others (Carey, 2011). Stephen Hayes, the founder of acceptance and commitment therapy, has openly discussed his experiences with panic attacks (Gloster, 2020; TEDx Talks, 2016). Clearly, there are psychologists who have experienced their own mental health struggles; research has documented such a fact. But could such a phenomenon be viewed as an asset within the profession?

The psychologists who have experienced mental health struggles could be described as "wounded healers." The wounded healer is an archetype that describes a provider who has participated in the healing process of their mental health struggles and, as such, can utilize the essence of their own healing experiences to provide more effective healing to others who are experiencing mental health concerns (Zeruvabel & Wright, 2012). Indeed, mental health providers have reported being influenced by their own experiences with pain and suffering regarding their dedication to work as mental health providers (Farber et al., 2005). It has been hypothesized that mental health providers whose life experiences of mental health struggles and suffering can utilize said experiences to heal their patients (Zerubavel & Wright, 2012). Still, it is important to examine the struggles of psychologists, including their mental health concerns that

occurs throughout their careers. Afterall, it has been documented that psychologists continue to experience mental health struggles even after completing graduate school.

One study based in the United Kingdom found that nearly 63% of 425 clinical psychologists endorsed a history of experiencing mental health concerns at least once in their lives (Tae et al., 2018). Approximately 70% of clinical psychologists reported having experienced mild to moderate depression, with almost 13% of clinical psychologists experiencing severe depression (Tae et al., 2018). About 42% of clinical psychologists reported experiencing anxiety (Tae et al., 2018). Clinical psychologists additionally reported experiencing eating disorders (11%), addiction (4%), psychosis (3%), and bipolar disorder (1%) (Tae et al., 2018). It would be suggested that clinical psychologists within the United Kingdom have experienced severe mental health experiences. What then about psychologists within the United States?

Some studies based within the United States have stated that approximately 60-70% of psychologists have experienced mild to moderate mental health struggles at least once in their lifetime (Mathison, 2020). Psychologists have also reported higher lifetime rates of depression and anxiety than the general population (Mathison, 2020). One study estimated that 70% of psychologists had experienced at least one mental health issue in their lifetime (Mathison, 2020). Within this sample, 35% experienced a depressive disorder, 21.7% experienced an anxiety disorder, and 9.8% experienced posttraumatic stress disorder (Mathison, 2020). Other lifetime mental health experiences endorsed within this group included experiencing: eating disorder (9.8%), adjustment disorder (4.9%), bipolar disorder (2.8%), obsessive-compulsive disorder (2.8%), substance use disorder (2.8%), dissociative identity disorder (0.7%), and attention-deficit/hyperactivity disorder (0.7%) (Mathison, 2020). It is estimated that approximately 10% or

less of psychologists have experienced severe mental health concerns, such as psychosis, bipolar disorder, active suicidal ideation, and psychiatric hospitalization (Mathison, 2020). A fair number of psychologists have clearly faced mental health experiences within their profession. It is worth asking: what unique work stressors do psychologists face that may be exacerbating or forming such psychopathology?

It is not new to question how a psychologist job may impact their mental well-being. Sigmund Freud reported that psychologists could reasonably expect to experience adverse psychological effects given the nature of the profession (Freud, 1933). Indeed, psychologists reported that they endure high levels of personal distress related to their chosen profession (Guy et al., 1989; Pope & Tabachnick, 1994). Considering the manner of psychotherapy, psychologists face exposure to individuals experiencing extreme distress. Repeated exposure to stories of trauma and witnessing the effects of trauma on multiple clients over a period could leave psychologists vulnerable to experiencing vicarious trauma or burnout.

Vicarious trauma is a manifestation of traumatic symptoms where a person's belief system is negatively changed (McCann & Pearlman, 1990). Psychologists could additionally be at risk of experiencing burnout. Burnout has been described as a person experiencing the gradual onset of feelings of hopelessness and disillusionment surrounding their perception that their efforts do not make a difference in their work performance (Stamm, 2005). Psychologists could experience either, both of, or neither of vicarious trauma nor burnout. There are clearly negative effects of the job that psychologists may experience. Given their profession where they are the ones used to helping individuals experiencing mental health issues, it is questionable to wonder how, or if, psychologists reach out for help with their own mental health problems.

Psychologists' Help-Seeking Behaviors

Psychologists have reported experiencing mental health concerns for themselves at rates like, and higher than, the general population (Gilroy et al., 2002; Mathison, 2020; Pope & Tabachnick, 1994; Tay et al., 2018). One examination of psychologists' personal experiences of mental health disorders showed that 61% of 476 psychologists endorsed experiencing at least one depressive episode (Pope & Tabachnick, 1994). In a 2002 study of 425 counseling psychologists, 62% of participants considered themselves currently depressed (Gilroy et al., 2002). A recent study estimated that 35% of psychologists had experienced a depressive disorder at someone time throughout their lifetime (Mathison, 2020). As it is not uncommon for those with depression to experience suicidality, clinical psychologists have also endorsed experiencing suicidality within their careers.

A 2010 study reported that clinical psychologists endorsed high rates of suicide attempts and suicidal ideation (APA, 2010); half of these clinical psychologists reported that they had not disclosed or sought help for experiencing suicidal thoughts (APA, 2010). When it comes to counseling psychologists, about 40% of them have endorsed experiencing suicidal ideation or behaviors (Gilroy et al., 2002). Approximately three percent of psychologists in general have endorsed that they had a history of psychiatric hospitalization (Gilroy et al., 2002; Pope & Tabachnick, 1994). So, there is an obvious range of psychologists seeking help with suicidality, with up to half of psychologists experiencing suicidality not reaching out for help and a low percentage going through with a psychiatric hospitalization. It is necessary to wonder what may impact psychologists from engaging in help-seeking behaviors.

Psychologists face additional stressors when engaging in help-seeking behaviors, such as psychotherapy with themselves as the client (Mathison, 2020). Psychologists have noted that one

such struggle is the professional familiarity of therapists in their surrounding area (Mathison, 2020). Mental health professionals have additionally reported having preexisting relationships with therapists potentially available to them, which made it difficult to find someone from whom to seek help (Mathison, 2020). Another reason psychologists may not reach out for help could be due to the accessibility of services within the location they are living in. For example, psychologists operating within rural areas are often isolated from other mental health providers, which may contribute to additional obstacles to obtaining psychotherapy for themselves (Helbock, 2003). Psychologists continue to experience barriers to reaching out and receiving treatment for their personal mental health issues.

When psychologists expect to face stigma and discrimination, particularly on the professional level, they are less likely to reach out for professional support for themselves (Mathison, 2021). Indeed, psychologists who have denied engaging in help-seeking behaviors despite experiencing their mental health concerns report perceiving that doing so could harm their professional credibility among colleagues and negatively impact their careers (Mathison, 2021; Tae et al., 2018). Psychologists have also endorsed feelings of shame and worry as various reasons for not seeking help for their mental health struggles (Tae et al., 2018). Despite these vast barriers, psychologists still have endorsed obtaining help for their mental health.

There appears to be many psychologists who have reached out for help to deal with their personal mental health struggles. In one study based in the United States, approximately 76% of psychologists reported receiving professional treatment for a mental illness (Mathison, 2020). Of these participants, approximately 60% of psychologists have received psychological treatment from doctoral-level psychotherapists, and 41% have received treatment from master-level

psychotherapists (Mathison, 2020). There is limited research on psychologists and help seeking behaviors of psychologists outside of the United States.

Psychologists within the United Kingdom have also largely endorsed seeing out treatment for their own mental health concerns. One study on help-seeking behaviors of psychologists in the United Kingdom found that for psychologists who had endorsed experiencing a mental health problem, 84% of participants sought help (Tae et al., 2018). Of the participants who sought treatment, 45% of psychologists received treatment from general practitioners, 37% saw a private psychotherapist, and 11% met with a psychotherapist through the United Kingdom's universal health care system (Tae et al., 2018). A smaller group of psychologists (16%, 46 individuals) denied seeking help from others (Tae et al., 2018). Psychologists within the United States clearly were also able to break through extrinsic and intrinsic barriers to receiving treatment for experienced psychopathology. What about the psychologists who end up not reaching out for treatment?

There could be negative consequences of psychologists not engaging in help-seeking behaviors for themselves. Hesitation or refusal of psychologists to reach out for mental health aid for themselves could put them at risk for an increase in impairing symptomology (Barrett et al., 2007). Additionally, when psychologists face personal mental health concerns, vicarious trauma, or burnout, their work quality with clients could be negatively impacted. Psychologists not receiving psychological services for their treatment could experience an increased vulnerability to experiencing countertransference and compassion fatigue (Zerubavel & Wright, 2012). Psychologists whose work is impacted by their personal mental health could be considered “impaired.”

A psychologist is considered impaired when their personal problems negatively influence the type of care a client receives, which puts the client at risk for experiencing harm. It has been documented that psychologists, indeed, do face impairment. In 1986, 456 psychologists reported on their beliefs regarding practicing ethical principles (Pope et al., 1987). Over half of that sample, nearly 60%, endorsed that they have rarely or more often worked when they were too distressed to be effective in their role as a psychologist (Pope et al., 1987). Additionally, nearly 6% of the psychologists endorsed that they rarely conducted therapy while consuming alcohol (Pope et al., 1987). A few years later, 318 psychologists reported on their experiences with personal distress and its impact on client care (Guy et al., 1989). Approximately 74% of psychologists endorsed experiencing personal distress within the past three years (Guy et al., 1989). Of that group, approximately 36% reported that the quality of client care decreased, while almost 5% reported that their distress resulted in "inadequate treatment" (Guy et al., 1989, p. 48). These are old studies; however, it shows that psychologists facing issues with impairment and personal mental health issues, including substance use, is something that has been documented and should be taken seriously. There remains a difference between an impaired psychologists and a wounded healer, which was discussed earlier.

It is important to note that the "impaired" psychologist differs from the "wounded" psychologist. An impaired psychologist is actively experiencing exacerbating distress and suffering, which overflows into their work. A wounded psychologist may share mental health struggles but not to the extent that they currently experience professional impairment. Instead, the wounded psychologists could draw upon their self-healing and help-seeking experiences as a positive tool for providing effective services to clients. Still, psychologist experiencing impairment should not be taken lightly.

To the author's knowledge, recent studies of psychologists and impairment have yet to be conducted. Nevertheless, impairment in the field of psychology is an important topic. The American Psychological Association's Code of Ethics describes the requirement for psychologists to engage in behaviors that limit their personal problems from negatively impacting their work-related competency (American Psychological Association, 2017). Engaging in such behaviors requires psychologists to be self-reflective on how their personal concerns could negatively impact their work and client care.

In sum, psychologists report experiencing high levels of distress and psychopathology throughout their careers. Psychologists engage in the treatment of their mental health concerns, which arguably provides positive, unique treatment variables. Therefore, it can be argued that clinical psychology graduates with a history of mental health and who experience psychological distress in graduate school reflect current psychologists' lived experiences.

Acknowledgment of COVID-19

Given its historical significance, it is important to acknowledge the COVID-19 pandemic, especially when investigating the lived experiences of a group immediately impacted by the COVID-19 outbreak. Graduate students have typically reported higher rates of experiencing psychopathology and increased distress compared to the general public before the COVID-19 outbreak (Forrester, 2021). It is well documented that individuals who have lived through a human-made or natural disaster can experience an exacerbation of mental health concerns (Goldmann & Sandro, 2014; Makwana, 2019). The emergence and continued existence of the COVID-19 pandemic has already impacted graduate students' mental health and functioning (Kee, 2021; Woolston, 2020).

One large study surveyed graduate students shortly after the outbreak of COVID-19 and again in 2020 (Chirikov, 2021). Of *N*=8,354 graduate students from spring 2019, 15% endorsed experiencing anhedonia or feelings of depression, and 26% endorsed feelings of nervousness or difficulty controlling worry (Chirikov, 2021). A later survey of *N*=15,337 graduate students from 2020 found that 32% of graduate students endorsed experiencing anhedonia or feelings of depression, and 39% of graduate students endorsed feelings of nervousness or difficulty controlling worry (Chirikov, 2021). It will be essential to continue to monitor research regarding the interaction between graduate students' mental health and the continuing pandemic of COVID-19. Therefore, this study acknowledges the cultural significance of the impact of COVID-19 on clinical psychology graduate students.

Statement of the Problem

Graduate students from various educational fields can experience multiple stressors that arise from the potentially harsh transition to life as a graduate student. Such stressors could contribute to graduate students endorsing increased rates of psychopathology that are disproportionally higher than the public. Clinical psychology graduate programs offer additional unique stressors that could further influence students' experiencing unhealthy stress levels and exacerbate student psychopathology. This study adds to the body of literature regarding the well-being of clinical psychology doctoral students and the growing mental health crisis within graduate education.

Purpose of Study

The purpose of this study was to amplify the voices of graduate students with histories of psychopathology and their experiences of navigating current mental health concerns and training demands within their clinical psychology doctoral programs. Individuals who have received

official psychological diagnoses face increased stressors and risk for psychopathological-induced impairment. There is a need for research to emphasize these individuals' experiences in their own words. A qualitative methodological approach was helpful to further explore and provide rich descriptions of these individuals' lived experiences. Therefore, this study could aid in identifying novel interventions for combating the graduate student mental health crisis within clinical psychology doctoral programs. Results from this study could additionally be used to cultivate effective preventative strategies against stressors experienced by psychologists (i.e., internalized, and professional stigmatization psychologists face for experiencing mental health concerns, burnout, impaired professionalism, etc.).

Research Questions

The following questions guided this study:

Grand Tour Question

What are the lived experiences of clinical psychology Ph.D. students who have a history of mental health diagnoses and experience current psychological distress as they manage educational/training demands and administer psychological interventions to clients?

General Questions

1) What have your experiences in graduate school been like in terms of being a clinical psychology Ph.D. student while simultaneously having your own history of mental health diagnoses and current presentation of mental health concerns?

2) What other factors or situations have influenced your experiences (as a clinical psychology Ph.D. student with a history of mental health diagnoses and current mental health concerns)?

Sub Questions

Resiliency within Educational Demands/Training

- How have you navigated graduate school demands and expectations as a graduate student with a history of mental health diagnoses and current mental health concerns?

  Focus on experiences of graduate student coursework/research demands.

- How would you describe your journey in graduate school thus far? What have you found to be the most difficult? The most surprising?
- On an individual level, how have you managed/coped with pressures of being in graduate school?

  Focus on obtaining input on self-coping/interventions/strategies.

- What support (if any) have you received from your advisor, peers/cohort, program faculty, program leadership, and university disability services?

  Focus on obtaining input on helpful interventions/strategies that came from OTHERS, not the participant.

- What advice would you give other people who have also had a history of mental health concerns prior to graduate school?

Wounded Healer Identity / Clinical Trainee Identity

- Have you heard of the concept of a wounded healer? (*Read definition)* What is your reaction to hearing that? Agree/disagree? Emotions/thoughts?
- What does it mean to be a student clinician providing mental health services to others while having your own mental health journey and experiences?

  Focus on experiences of providing therapy/assessment to others/wounded healer identity.

- What is advantageous and/or disadvantageous about having your own mental health history and providing treatment for others?
- How might your own mental health history and current exacerbated symptoms guide your clinical practice as you provide treatment for others?

COVID Impact

- How has the emergence of COVID impacted you (regarding being a clinical psychology graduate student with a history of mental health diagnosis and current mental health concerns) and the potential support and hardships you have experienced thus far?
    - How has this disaster allowed for a greater understanding of mental health disabilities, OR has it been 'business as usual,' OR have there been greater expectations?

Emergent Questions for 1st Interview

- If you could say something to your past self who has yet to enter the program, what would you say?
- Let's say a friend who has experienced a similar mental health journey as you is interested in applying to clinical psychology graduate program. What would you say to them? Advice? Encouragement?

Emergent Questions for 2nd Interview

- What was it like reading the transcript from the first interview? Similarities/differences to now? Thoughts? Reactions?
- Are there any major events occurred since last meeting (for the first interview)? Good/bad?

  Focus on coursework, mental health, and clinical activities.

- Do you have any thoughts on the idea of self-care and managing mental health in graduate school?
- Is there anything you would change in your program?
- Would you consider yourself to be financially stable?
- Would you do anything differently as you reflect on your journey so far?
- What do you envision for your future as a psychologist?
- What are your strengths?

Method

Research Design

There is a need to amplify the voices of clinical psychology graduate students who demonstrate remarkable resiliency while shouldering a mental health history and experiencing recent distress. Greater awareness of this population's experiences is needed to identify and implement improved supportive strategies. Therefore, a qualitative approach for this study was utilized. Qualitative research is utilized to understand "how people make sense of their lives and their worlds" (Merriam & Tisdell, 2016, p.25). A qualitative study aims to "uncover and interpret how that meaning is constructed" (Merriam & Tisdell, 2016, p.25). Therefore, a qualitative approach examines how individuals make sense of their own experiences, amplifying participants' voices.

A qualitative framework provided the necessary structure to address the current study's areas of interest. Qualitative research emphasizes an in-depth exploration of participants' lived experiences following a lengthy data collection and analysis process. The researcher relied on the use of induction to inform research findings, which allowed the researcher to identify and

describe emerging concepts and themes that arose from the data (Creswell & Poth, 2018; Merriam & Tisdell, 2016).

Social Constructivism Framework

The interpretive framework for this study was guided by social constructivism. Social constructivism examines the interaction between a person's lived experiences and the surrounding content of said experiences (Creswell & Poth, 2018). This paradigm considers the interaction between lived experiences and the surrounding environmental context to hold the key to understanding a person’s reality (Creswell & Poth, 2018).

The essence or "meanings" of individuals' experiences are not considered ultimate truths of reality. The essence (i.e., meaning) of lived experiences cannot exist by itself and therefore cannot be predefined. Instead, the meanings underlying individuals’ experiences are influenced by the world they live in (Creswell & Poth, 2018). Therefore, the essence of these lived experiences is influenced by social expectations and historical and cultural norms and factors (Creswell & Poth, 2018).

The investigator focused on the complexity of the interaction between lived experiences and the surrounding environmental factors. The essence of lived experiences differed significantly between individuals and their interactions with environmental beliefs and influences (Creswell & Poth, 2018). Research with a social constructivism framework heavily relies on the participants to report their perceptions and describe relevant environmental contexts that influence the construction of the essence of their lived experiences (Creswell & Poth, 2018). Therefore, an inductive approach was utilized to identify the essence of a phenomenon (Creswell & Poth, 2018).

Phenomenology Approach

A phenomenological study examines the individuals' common meaning or essence that emerges from a specific experience or phenomenon (Creswell & Poth, 2018; Merriam & Tisdell, 2016). Findings from phenomenological research aim to provide a rich description of the essence that makes up individuals' lived experiences of a shared phenomenon (Creswell & Poth, 2018).

While all qualitative research approaches stem from phenomenological philosophy, a qualitative phenomenological study holds unique considerations compared to other qualitative methods (Creswell & Poth, 2018). The phenomenology philosophy involves the interest of a specific experience and how that experience develops into a collective consciousness (Merriam & Tisdell, 2016). Phenomenological research first identifies a particular phenomenon that individuals have experienced. A phenomenological study aims to describe the very nature of individuals' specific lived experiences (Creswell & Poth, 2018; van Manen, 1990). During this process, phenomenological researchers work to withhold judgment regarding the "reality" of the phenomenon. Researchers are expected to be reflexive throughout the study. Researchers must acknowledge how their experiences and biases might influence data interpretation. Phenomenological researchers then attempt to set aside their own beliefs and experiences to more clearly understand the lived experiences reported by the participants (Creswell & Poth, 2018). Researchers typically facilitate individual interviews or small focus groups for the data collection process. Data analysis typically entails a "bottom-up" approach when reviewing collected data. The researcher identifies significant statements that will later make up larger categories of specific themes.

Positionality Statement

Qualitative researchers typically provide a written statement that reviews personal beliefs and experiences that likely have influenced their approach to engaging in research. The researcher may complete a positionality statement in the first-person narrative to better reflect the researcher's potential influences. Therefore, I will utilize a first-person structure to inform readers of my positionality.

I possess various identities and have undergone multiple life experiences that will likely influence the current study's findings and recommendations. For example, I am a cisgender, White American woman. I am conscious of how inherent privileges manifesting from unequal societal power structures could influence my beliefs and actions.

I have a strong drive to promote and engage in advocacy and social justice initiatives. Therefore, my research inherently takes on feminist values and viewpoints. My employment history has consisted of working in a rural women's center and an urban LGBTQ+ resource center. Both locations primarily focused on providing direct assistance and professional referrals that emphasized supporting and guiding students affiliated with four-year universities.

After completing my undergraduate degree in psychology with a minor in women and gender studies and a certificate in LGBT studies, I entered a clinical psychology Ph.D. program. I value the work of mental health providers. I believe it is essential in my work to empower clients in ways that will lead them to enact meaningful change in their lives, improving their overall well-being.

On a deeply personal note, I provide a statement regarding my own mental health experiences. I have an intensive history of experiencing depressive and anxiety-related symptoms. As a result of these symptoms, I have historically experienced debilitating distress

and impairment in my academic work and social life. I have learned ways to manage and cope with reemerging mental health issues in highly stressful environments.

I am nervous about providing such personal information; however, I believe the stigma of mental illness would lessen within the psychology profession if more mental health providers shared their personal experiences with mental health. I maintain the belief that other clinical psychology doctoral students are just as dedicated as myself to helping others who experience distressing mental health symptoms. I believe that this study allows for further dialogues about the resiliency of individuals with a mental health history who continue to provide effective psychological treatment to others.

Data Collection

Moustakas (1994) recommends asking participants broad questions regarding their lived experiences of the designated phenomenon and relevant contexts that have impacted these lived experiences. Participants for the current study were initially asked predetermined questions, with the flexibility to allow for further questioning and clarification. The participants were invited to participate in two one-hour interviews via an online videoconferencing platform (i.e., Zoom). Creswell and Poth (2018) noted that phenomenological researchers "often (conduct) multiple interviews with the same individuals" (p.150). Additionally, this aligns with the feminist and social justice ideals of this study by offering multiple chances for participants' voices to be heard.

Recruitment

The University of South Dakota Institutional Review Board (IRB) approved the study before starting the recruitment process. Participants received financial compensation for their study participation. At every interview meeting, participants received one $50 prepaid credit

card; this allowed them to utilize their payment where they saw fit. Participants were asked to participate in a follow-up interview and be compensated $50 again for their time. Following committee approval, the researcher met again with participants and presented data findings (see below for more details about this meeting); No financial compensation was given for this final meeting.

The study utilized a mixed purposeful sampling approach, which entailed utilizing multiple qualitative sampling approaches to better inform the study's credibility (Patton, 1990). Purposeful sampling is the act of deliberately choosing participants for a study based on specific criteria (Merriam & Tisdell, 2016). Qualitative research typically uses purposeful sampling (Merriam & Tisdell, 2016). Purposeful sampling approaches emphasize the importance of examining information-rich cases to understand a specific phenomenon in-depth (Merriam & Tisdell, 2016; Patton, 1990; Patton, 2015).

Criterion sampling was utilized to identify individuals who have endorsed specific participant inclusion criteria required for the study (Patton, 1990). Participants were enrolled in a clinical psychology Ph.D. program based in the United States of America and completed at least two full years of graduate school. Participants were previously diagnosed with a psychological disorder before entering their current program. Participants also were currently experiencing psychological distress and/or hold a diagnosis for a recent episode of a psychological disorder. It was preferred for participants to complete one initial interview and one follow-up interview.

A minimum of five participants providing rich case information about the study's research purpose was deemed sufficient for data analysis, as recommended by Polkinghorne (1989) and echoed by Creswell and Poth (2016). Qualitative research emphasizes the importance of in-depth exploration of each participant's lived experiences, which becomes clear following a

lengthy data collection and analysis process. The purpose of this study was not to generalize findings. Therefore, a larger sample size was unnecessary for qualitative data analysis.

Snowball/chain sampling was utilized as a sampling strategy to search for eligible participants willing to engage in a research interview. The researcher sent a link to access a short online screening survey to appropriate listservs (i.e., Google Groups "Psych Grad Student Research Participation Requests" group). At the end of the screening survey, all participants were provided a link to said screening survey and asked to distribute it to individuals who might be interested in participating in this study.

Screening Protocol

Participants clicked on the provided link to take them to a page with more information about the study. The page notified the participants of the IRB approval. The purpose of the study was described as the intent to examine current clinical psychology graduate students' experiences with personal mental health concerns. A short survey was first used to identify participants who met the study criteria.

The expected time to complete the screener survey was noted so participants could make an informed decision on choosing to participate in the screener survey. There were no stated direct benefits or compensation for completing the screener survey. Potential risks that might have been experienced when completing the screener survey included some mild discomfort related to research content of personal mental health history and current level of distress. The national suicide telephone hotline number was listed at the bottom of the screen as well. The lead researchers' and IRBs' contact information were additionally provided. It was noted that the participant's participation was voluntary. By clicking the 'continue' button, they consented to begin the screener survey. Again, the participant could exit the screening survey at any time.

Participants who met the study criteria were invited to virtually meet with the lead researcher for a total of two one-hour semi-structured interviews via Zoom.

Participants confirmed or denied if they were currently enrolled in a clinical psychology Ph.D. program within the United States; they were not asked to identify the program. Participants noted how long they have been in the current graduate program. Participants confirmed or denied if they had ever been formally diagnosed with a psychological disorder (i.e., developmental, learning, mood, personality disorder). Participants confirmed or denied if they had a diagnosis of a current psychological disorder. Participants confirmed or denied if they have been recently distressed or concerned about their mental health.

If the participant positively answered all screening items (i.e., met study criteria for participants), the participant then received more information regarding the actual study participation. Interviews focused on participants' mental health experiences in graduate school. Participants selected "yes" or "no" when asked if they would be willing to commit to two one-hour individual interviews over an online conferencing platform (i.e., Zoom). During the interviews, participants were asked to provide further information regarding their mental health experiences throughout graduate school.

Participants were notified that the interviews would be video, and audio recorded strictly for data collection purposes. The recordings were stored electronically on a secured platform (i.e., https://www.box.com). Once the interview was transcribed, the researcher deleted the video and audio recordings. Participants were compensated $50 per one-hour interview for a potential $100 financial compensation.

The researcher made every effort to protect participant confidentiality. Given the potential small field of psychologists, there was a risk that participants could be identifiable. To

make this more unlikely, each participant was asked to choose a pseudonym, and that name would be the only one attached to any transcription or reference to the participant. Participants' names, contact information, and pseudonyms were kept on an encrypted flash drive in a locked drawer in the researcher advisor's office.

Possible participant risks included feelings of discomfort when discussing personal mental health experiences or concerns about their story becoming public. However, the study avoided disclosing participants' real names. Participants had a chance to review transcriptions and study findings, which allowed the participants to bring up potential identification concerns before the future publication of results.

The participants were encouraged to contact the IRB and/or the lead researcher for further clarification/questions about this study. The participants were asked if they consented to be contacted by the lead researcher (Hannah Flanery, M.A. Hannah.Flanery@usd.edu) via email. The participants were asked to provide their preferred name and preferred email address. By clicking a box and clicking the submit button, the participants said they consent to participate in this research study. The researcher then contacted the participants via email to schedule the first interview.

Interview Protocol

The lead researcher reviewed the IRB participant consent form during this initial meeting. The lead researcher oriented the participants to the purpose of the study, the time commitment being asked of them for participating in this study, and the general expected timeframe of study progression. The participant was reminded of the financial compensation they will receive at the end of each interview meeting. The lead researcher answered any additional questions and provided further clarification as needed. The participant was given the

opportunity to choose a pseudonym to be used in the study. The researcher then proceeded with the interview questions.

Following the initial meeting, the researcher reviewed the data collected and transcribed the interview. For the second meeting, the researcher sought clarification, made sure the transcribed material was accurate, and asked novel questions. Following the second meeting, the researcher completed data analysis, and findings were compiled.

During the third and optional final meeting between the participant and the researcher, the researcher provided a presentation of study results. The participant was given the opportunity to provide feedback regarding the study conclusions. The researcher ensured the participant felt that the findings represented their experiences well.Throughout the interview process, participants experienced some distress related to the content of the study questions. The researcher assessed participant discomfort throughout the study. At the beginning of each interview meeting, the researcher asked the participants to rate their current level of distress on a scale of one to ten. Answers of "one" communicated that the participant experienced no levels of distress, while answers of "ten" indicated the participant was experiencing highly intense levels of distress. If the participant answered "eight" or above, the interviewer would have rescheduled the interview to a different date. The participant would have been reminded that they are free to end participation in the study at any time.

The researcher planned to pause the interview if a participant had become upset or triggered by talking about their experiences. The researcher would have utilized her clinical experience to initiate effective emotional regulation by administering grounding techniques (i.e., deep breathing and imagery exercises). The researcher would have then re-assessed the participant's current level of distress. If the participant had provided an answer of eight or above,

the researcher would have suggested ending the interview, allowing the participant to engage in resources promoting self-care. The researcher would have offered the option of rescheduling the interview. The researcher electronically shared a pre-made document containing national crisis hotline resources. The participant would have been reminded that they were free to end participation in the study at any time. If the participant desired to continue with the interview, the researcher would have suggested taking a five-minute break. The researcher would have indicated that the participant takes a short walk, drink a glass of water, or talk about a non-relevant research topic. After the break, the researcher would have reassessed the participant's current level of distress. If the participant answered eight or above again, the researcher would have ended the recent interview. The researcher planned to initiate the use of grounding techniques again. The researcher would have highlighted the list of resources provided for national crisis hotlines. The researcher would have reminded the participant that they were free to end participation in the study at any time. If the participant desired to continue with the study, the researcher would have rescheduled the interview for a different date.

Data Analysis

The researcher electronically transcribed all the interview recordings via Happy Scribe, an online automatic transcription service. (See https://www.happyscribe.com/security for information on its well documented security protocols). For each interview manuscript, the researcher eliminated potential identifying information provided during the recordings. The researcher then reviewed the transcriptions while observing the interview recordings to double-check possible transcription errors for the said interview. The researcher then deleted the corresponding interview recording.

The researcher read through the interview recording transcription in its entirety. The researcher then began the coding process. The researcher noted specific responses that appeared relevant to the study's guiding research question. The initial codes for the study were in the form of short phrases or quotes regarding the researcher's interpretation of these marked participant responses.

The researcher chose to stop participants entering the study at 14 participants. Creswell and Poth (2018) recommended a minimum of five participants to obtain potential saturation of the results; this study exceeds that. Saturation was already being seen during the first set of interviews during which participants were providing similar narratives or stories to questions that were asked. Saturation was then, again, identified in the data analysis process which ended up having over 2200 initial codes for the 14 initial and seven second interviews. The reason why the initial interviews was not stopped once saturation was suspected, was that it felt difficult for the researcher to turn people away who wanted to participate and share their story, especially when the researcher was hearing messages from participants that the study was providing a unique experience to share their stories.

Once the interviews were completed and participants were no longer being recruited, the researcher conducted analytical coding on the initial codes previously created. Analytical coding involves the process of sorting the initial codes into broad groups (Merriam & Tisdell, 2016). This process began with rereading through the initial codes and begin sorting them in a way that conveys their likeness in concept (Merriam & Tisdell, 2016). These groups comprise emerging essences from the initial codes (Merriam & Tisdell, 2016). It goes beyond superficial descriptions; therefore, the broad groups held more interpretative value into their grouping even this soon in the coding process.

The researcher then organized the groups created from the analytical coding process into more significant categories that encompassed similar data content. The researcher conducted another level of coding on these larger categories to generate official themes. This coding process allowed the official findings to be derived from the data provided during the participants' interviews. The researcher shared the findings with the dissertation committee chair, who provided feedback. The themes are presented in the Results section.

The researcher memoed her thoughts and reactions that arose from engaging in the study throughout this process. Memoing promoted self-reflection and provided an audit trail of the actions taken within the data analysis process.

Integrity Measures

The researcher utilized multiple efforts to ensure the integrity of the study. First, the researcher provided a positionality statement where she disclosed aspects of her own beliefs and lived experiences that likely influence research findings (Creswell & Poth, 2018). Second, the researcher remained self-reflective throughout the completion of the study. The researcher memoed her thoughts and reactions that arose throughout the study to increase and maintain self-awareness of potential influence. Third, the researcher invested in providing rich descriptions of the study context and data findings. Detailed descriptions included direct quotes supplied by participants to highlight a greater understanding and increase accountability within data analysis (Creswell & Poth, 2018). Fourth, throughout the coding process, the researcher actively searched for disconfirming evidence to account for participants' varied interpretations despite experiencing a shared phenomenon (Creswell & Poth, 2018).Fifth, the dissertation committee chair and the researcher engaged in several conversations regarding themes and subthemes. Lastly,

dissertation committee members reviewed and provided constructive feedback regarding the study's methodology, data analysis, and final study results and discussion.

Ethical Considerations

The researcher desires to engage in ethical research. The participants in this study arguably fall within vulnerable populations. Therefore, the researcher took on a cultural humility approach throughout this study. The researcher took action to ensure the data collected and findings presented from this study do not inadvertently cause harm to this population. The researcher was highly motivated to provide results that will contribute to a greater understanding of their lived experiences and provide better guidance to clinical psychology directors and faculty on supporting this population. The researcher sought to reach an acceptance and agreement of the data findings with all participants throughout the data collection and analysis processes.

Results

Participants

Within this study, participants were fourteen clinical psychology Ph.D. graduate students who endorsed having a history of mental health struggles and a recent or current experience with mental health struggles or distress. Seven participants returned to complete the second interview, which allowed for an opportunity to ask emergent, novel questions; there is no known pattern or reason for why these seven chose to return to the study compared to the other seven participants who decided to not return.

The students' locations were not limited except to living within the United States of America. Demographic data was limited to better protect participants' privacy and identity. Exact

ages were not collected. Students could share their demographic information; some felt comfortable disclosing more demographic information than others. See Table 1 for demographic information.

Students ranged from being in the third year of graduate school to holding a post-doctoral position; No explicit differences due to position in graduate school were noted from stories. All had experience providing psychological clinical services, such as psychotherapy and/or psychological assessment. Students' experiences with psychological symptomology qualitatively ranged from minimal to severe in severity and impairment. Students endorsed ranges of symptoms and diagnoses broadly encapsulated by anxiety, depression, eating disorders, substance use, and suicidality.

Table 1

Demographic Data for Sample

Results	Demographic Summary[1]
Guadalupe	• Trans Woman • Third year • History of dysthymia/persistent depressive disorder and generalized anxiety disorder • Currently diagnosed with posttraumatic stress disorder, generalized anxiety disorder, dysthymia, and attention-deficit/hyperactivity disorder. Recent discomfort.

	• Identity: Second generation Mexican American, trans woman. Conscious about social justice, cultural diversity, and interaction between her own and others' cultures.
Hannah	• Woman • Third year • History of panic disorder • Current suspected diagnosis of major depressive disorder. Recent discomfort. • Identity: From the East Coast, low-income background, the first person in the family to attend college, Latina. Creative person and very service oriented.
Helen	• Woman • Fourth year • History of generalized anxiety disorder • Current experience with anxiety. Recent discomfort. • Identity: Clinical psychology graduate student and a person outside of being a clinical psychology graduate student. Values work-life balance.
Joshua	• Man • Fourth year • History of anxiety disorder and generalized anxiety disorder • No current diagnosis. Recent discomfort.

	• Identity: 28 years-old, boyfriend, pet owner, friend, brother. Rural background, low-income resource family with single mother. Interested in disparities. Does home DIY projects (i.e., landscaping and home renovation).
Libby	• Woman • Fifth year • History of generalized anxiety disorder, major depressive disorder, adjustment disorder, and post-traumatic stress disorder. • Current diagnosis of major depressive disorder, generalized anxiety disorder. • Recent distress. • Identity: Introverted, very quiet, experience and process things differently, great love of animals, wife to disabled veteran man, and trains service dogs.
Lola	• Woman • Sixth year • History of obsessive-compulsive disorder and generalized anxiety disorder. • Current diagnosis of obsessive-compulsive disorder. Recent distress. • Identity: Portuguese, clinical psychology doctoral student. Values family and friends, and passionate about her work
Mackenzie	• Cisgender Woman

	• Seventh year, on internship • History of anxiety, depression, tic disorder, and posttraumatic stress disorder. • Current diagnosis with anxiety, social anxiety disorder, and generalized anxiety disorder. Recent discomfort. • Identity: Heterosexual, White, Non-Hispanic/Latino, Christian nondenominational. Grew up in the south.
MC	• Woman • Sixth year, on internship • History of depression. • Current diagnosis of depression. Recent discomfort. • Identity: Graduate student, Vietnamese, cisgender, woman. Likes doing art, introverted.
Melissa	• Woman • Third year • History of panic attacks and anxiety. • Current panic disorder and generalized anxiety disorder. Recent discomfort. • Identity: Black cisgender bisexual woman, located in Midwest, grew up Christian. Likes traveling, big on community and spending time with loved ones and friends, chill, letting life come as it may, and more introverted as she becomes older.

Nichole	• Woman • Third year • History of posttraumatic stress disorder. • Current major depressive disorder. Recent discomfort. • Identity: Disabled with chronic health condition, White, female, cisgender. Values transparency
S	• Queer Woman • Fifth year • History of depression and generalized anxiety disorder. • Current depression and generalized anxiety disorder. Recent distress. • Identity: Child of immigrants, Polish culture, queer woman, low-income background, experienced homelessness, White woman.
Sarah	• Woman • Fifth year • History of depression and panic disorder. • Current depression, panic disorder, and attention-deficit/hyperactivity disorder. • Identity: White, bisexual, atheist. Values helping people overall, being an accepting person, being curious and interested in others.
Skipper	• Gender Queer Person • Sixth year, starting internship

	• Likely history of mood disorder, anxiety disorder and substance use disorder. • No current diagnosis. Perceived normative distress level for a clinical psychology graduate student. • Identity: Bosnian Serb, immigrant to US, gender queer person, queer identity, and clinical psychologist in training. Constantly evolving, eager to learn, eager to grow, enjoys diverse company, deep, and honest relationships, pursuing big career goals. Not very fixed in identity.
Sydney	• Woman • Graduated, at post-doctoral position • History of dysthymia, anorexia, major depressive disorder • Current burnout and ongoing depressive symptoms • Identity: Flexible person emotionally and mentally, values interpersonal roles, and values being student. Easy going and not very anxious.

[1]Demographic data purposefully limited to protect anonymity.

The following table represents the final themes and subthemes of this study.

Table 2

The lived experiences of clinical psychology Ph.D. students who have a history of mental health diagnoses and experience current psychological distress as they manage educational/training demands and administer psychological interventions to clients.

Heavy Emotional Experiences	**Advisor/ Mentor**	**Disclosure**	**Unique Relationships with Psychotherapy**	**Resiliency**
Distressing Symptoms	Quality of Experiences with Advisors	Disclosure from Faculty and Program	Personally Receiving Psychology Treatment	Coping Strategies
Struggles, Suffering, and Survival	Alignment with an Advisor	Student Disclosure Experiences	Providing Treatment as a Therapist	Advice for Other Students
Separation of Identity		Beliefs of Disclosures	Wounded Healer	

Heavy Emotional Experiences Theme

The Heavy Emotional Experiences theme is made up of messages from participants regarding the emotional struggles they faced in graduate school. There are three subthemes. The first subtheme is Distressing Symptoms. The second subtheme is Struggles, Suffering, and Survival. The third subtheme is Separation of Identity.

Distressing Symptoms Subtheme

Participants recalled experiencing a wide variety of distressing symptoms, which included experiencing fluctuating moods, developing anxiety and depressive symptomology, feelings of grief, burnout, and imposter syndrome.

Since being in graduate school, participants noted that their mental health had been "up and down." Sydney described her experiences with fluctuating moods: "(I was) experiencing success and feeling happy for like five minutes and then going back into self-doubt or self-deprecation." One participant described their mental health as a stock market trend, while another participant described their mental health as a rollercoaster. The next section of this subtheme focused on feelings of anxiety and panic.

Participants endorsed experiences of symptoms explicitly related to feelings of anxiety and panic. They reported experiencing distressing anxiety symptoms due to being in graduate school. Joshua described the graduate school experience as having "more pressures, more anxiety … and less freedom." Joshua described the presence of anxiety in graduate participants as being a normative and expected experience:

> You get a fair amount of people (who) are pretty anxious overall in the program. It's quite noticeable. So if someone really jittery, … I get it. No one really hides it too much. It's not a secret … Occasionally people will talk explicitly about it, but it's never an intrigue. Whenever you're like, this person's got anxiety. It's like, yeah, okay. Water's wet.

Multiple participants reported that during the second year of the program, they noticed increased feelings of anxiety and experienced panic attacks. Helen described participants as experiencing persistent feelings of anxiety: "In this level of education, we're all very

perfectionistic, we're all very good at what we do, but there's always that voice that is typically anxiety in the back of your head." Other participants also stated that anxiety was high during specific points in graduate school. Several participants described that they developed panic attacks after being told to produce more by their advisors and faculty. One participant discussed experiencing somatic symptoms such as their hands shaking and not being able to sleep during their second year of graduate school, which contributed to the massive feelings of anxiety they experienced. Another participant reported that anxiety experiences were the most challenging thing about their mental health that they have experienced since being in graduate school. Indeed, graduate school, in general, had one participant describing that they felt as though they became a more cautious person as time passed. Helen described that students experience "lots of those second-guessing, anxious thoughts." Other participants described experiencing anxiety related to issues surrounding racism within their program. Melissa reported that:

> Part of my anxiety was related to racism in my program. And for that, it was like, oh, well, take a leave of mental health. And I was like, you all are still going to be racist when I get back.

In contrast, other participants reported that they always had anxious tendencies even before entering graduate school and could not name a direct cause of their anxiety symptoms. As is typical with anxiety, participants endorsed experiencing depressive symptoms as well, which is discussed next.

Participants described experiencing more typical depressive symptoms, becoming irritable, snappy, and judgmental. They explained experiencing weeks-long depressive episodes, which left some participants not being able to get out of bed. As Hannah described:

> I feel like my biggest thing with my depression is just I just can't move. I'll just be like, it's so hard to get up and get going in the morning. And so, frankly, so many times I have done classes, like my first year from bed with my camera off (due to being remote from COVID), I literally didn't move. So that was super helpful. And nobody had to know. And I could still be accommodated.

Multiple participants described experiencing increased depressed mood beginning graduate school. Hannah described her mental health during her first year of graduate school: "I think my mental health probably hit the lowest it's ever been, I think, in that first year." Guadalupe shared her thoughts regarding her mental health since moving to her program's state.

> “My mental health has spiraled since moving here. I think about it all the time: Would I have been happier if I went to the other programs that accepted me? Would I have been happier if I stayed in (another state), where all my friends are?”

Other participants reported an emergence of depressed mood beginning their second year.

Participants additionally conveyed feelings of loneliness and disconnection from others. They reported feeling alone and having extreme loneliness. Several participants described feeling very lonely at the beginning of graduate school. Additionally, there were descriptions of a low number of sleeping hours and insomnia. Participants detailed only sleeping four to five hours a night as a normative experience. One participant discussed that, at one point, they had not slept a whole night in three weeks. Experiences with crying spells were also shared. Participants reported that they experienced “angry tears” and had “hysterically cried” at moments throughout their graduate school career. One participant reported that they “could cry at the drop of a hat” during their first year of graduate school. Another participant described noticing increased

moments of crying since entering graduate school. Mackenzie described moments leading up to her experience of crying in front of her advisor:

> I had read this article (where) there was someone in STEM, some male faculty member who had been really sexist … He had talked about how he didn't want to accept women graduate participants because they always cry … So going into graduate school, I had this fear of crying in front of a male advisor … I finally cried in front of my (male) advisor … The fact that I was crying made me cry harder because I was so embarrassed.

As is common with depression, participants endorsed experiencing suicidality. They described experiences of suicidality that they felt since being in graduate school. Multiple participants endorsed experiencing recent active and passive suicidal ideation. One participant reported feeling as though their program invoked feelings of suicidality. Guadalupe described her experience with suicidality:

> I would say for the most part (it) has just been a trajectory up until this summer where I became completely suicidal, which hasn't happened since undergrad, and which really pissed me off that I let the program get me to that place. (It) was scary that I so quickly got back to that place.

Yet another participant acknowledged they had previously felt suicidal and decided not to tell anyone about their suicidality. Participants additionally noted significant life events that impacted other heavy emotions, such as grief.

Participants recalled experiences with feelings of grief in graduate school that stemmed from outside life events. One participant described dealing with grief during moments in

graduate school. Another participant reported feeling as though there was no time in graduate school to process feelings of grief.

With focus on the heaviness of mood, participants additionally described dealing with burnout. Participants' experiences of burnout, which can be described as a state of exhaustion caused by extensive stress, emerged through the study. Multiple participants explicitly identified experiencing burnout. They reported experiencing ongoing experiences of burnout throughout the past year. Sydney stated: "I feel like a lot of the feeling of burnout or disappointment that I was feeling a year ago, I still feel."

Another participant contributed their feelings of burnout from multiple sources of stress to the point they felt they were receiving hate from multiple sources. Melissa described her experience with burnout:

> I think a lot of faculty members came to me and was like, yes, I was concerned about you burning out. Yes, I felt like you were doing too much, but you seemed okay. You kept producing, and so things were good … I wish (the faculty members) would have had the confidence to talk to me.

Participants endorsed struggles with additional distressing symptomology, which were conveyed through their endorsement of imposter syndrome. They embodied identifications of experiencing imposter syndrome, which can be described as experiencing feelings of self-doubt regarding one's accomplishments and academic status. MC described her experiences with self-doubt: "The intense scrutiny and the self-doubt and the expectations that I had for myself were really high (and I felt) like I'm not meeting it. People were totally seeing that I'm not meeting it. It felt overwhelming."

Participants explicitly named experiencing imposter syndrome throughout their graduate school experience. One participant reported experiencing a "sense of illegitimacy." Another participant noted that they experienced imposter syndrome in their first year of graduate school. Sydney described her experiences with imposter syndrome:

> I thought that I would feel, like, a sense of legitimacy and decline of impostor syndrome over time, and I definitely feel like it's been the opposite. I feel less kind of capable or, like, we all entered grad school feeling promising because it's so hard to enter grad school, and we obviously work very hard to do that. I don't know about everybody else, but I felt like many of us were really excited about, let's get going. This is awesome. We still have time to grow and learn and build our and now I feel like even though I have accomplished many things that I thought would make me feel legitimate and capable, I feel less and less so.

Other participants described having thoughts of wondering if they were supposed to be in graduate school, which highlights the self-doubt that is commonly found with those experiencing imposter syndrome.

Additionally, there were emergent messages of being in hiding. Participants had the feeling as though they were going to be "found out" about their inadequacies. One participant described it as a "weird fear of being in hiding." There was evidence of participants blaming themselves for their current situation and symptomology; there was a "you did this to yourself" attitude expressed by participants.

Struggles, Suffering, and Survival Subtheme

The second subtheme was Struggles, Suffering, and Survival, which documented the participants' personal emotional reactions towards the impact of adjusting and living through graduate school. As part of the second subtheme, participants described the largely negative feelings they had about themselves. They self-identified as failures, doing a poor job as graduate students, feeling as though they were in hiding, and had internalized messages of self-blame, and doubt. Participants elucidated feeling as though they were consistently failing and as though they were doing something wrong throughout graduate school. One participant described feeling foolish while another reported feeling as though they were undesirable friends. Participants described experiencing feelings of inadequacy that were cultivated throughout graduate school. They also explicitly reported experiencing feelings of self-doubt. One participant discussed that the worst part of graduate school was experiencing self-doubt. Another participant reported that they would have fleeting thoughts of happiness before again experiencing self-doubt.

Participants reported having thoughts that they were doing a poor job without having evidence for the thoughts. They reported feeling as though they were working too slow on projects. One participant reported that they internalized their performance in their program to mean they were defective. Additionally, another participant reported having a history of thinking they are not productive or motivated enough. One participant reported having the sense that there is always something more that needs to be done or completed.

MC generally stated that "graduate school is tough for your mental health." Participants experienced pessimistic thoughts, which include a sense of doom and disillusionment. They reported that they experienced spiraling, ruminating thoughts. Some participants noted experiencing feelings of uncertainty, which triggered stress and anxiety. Participants described

feeling defeated. One participant reported that they felt defeated when they had to apologize to faculty. Participants additionally reported on experiencing feelings of brokenness. One participant commented “I broke so quickly in graduate school.” Other participants described having moments where they “snapped” or emotionally fell apart. Libby conveyed one such experience:

> (I was) never ... able to process anything because it was just onto the next thing, onto the next thing, onto the next thing. Finally, I just snapped. I went into the worst depressive episode I have ever been in … My dissertation chair knows about my depressive episode because I broke down in her office a few times.

Participants explicitly described feeling stressed and experiencing mounting tension in their bodies. One participant reported experiencing so much stress in their body, that it led to a back injury. Another participant reported experiencing increased levels of stress since entering graduate school.

Participants described graduate school as an overwhelming experience. One participant reported feeling overwhelmed from the workload required of participants. Participants additionally described struggling throughout graduate school. They described feeling “on edge.”

One large component of this subtheme surrounds messages of suffering. Melissa described the moment she realized she was suffering: “I don't know how much more I have to give ... After that, I was just like, oh I have nothing to give any for. And I realized I was suffering.”

Some participants described being okay with suffering if it meant meeting their goals. Skipper described how a student changes with suffering and hardship that takes place during a graduate program:

> One of my supervisors … said it's kind of like shedding your skin the way a snake does. Going through that program, you do become a different person. So being aware of that, that you might unravel darkness that you didn't know you have, that you might be stretched beyond your limits at times ... So shedding the skin that's not you and finding the one that feels comfortable, but the process of shedding is not going to be comfortable.

Other participants reported that it was not a good mindset to suffer now for being better in the future. Sarah reported that "I hate that the road has been the way that it is to get to where I'm going." Participants questioned how good it would be if students did not have to suffer in graduate school. They also condemned the idea of suffering being a rite of passage for completing a doctoral graduate program. Helen described her thoughts on the idea of suffering within graduate school:

> There is still a really strong mindset of graduate students are supposed to suffer. This is us paying our dues. We're supposed to be working 100 hours a week and miserable and just doing what it takes to survive rather than actually learning while also being people … We don't say that professors are just supposed to suffer or that our patients even are just supposed to suffer because that's what it takes to get through it.

Libby wanted to share a message to professors of graduate students on the subject of graduate students and suffering:

> I would say just because you might have had a professor or a program that essentially broke you doesn't mean that you have to do that. That's not a rite of passage. You don't have to repeat the trauma with somebody else that you went through. It's okay to just realize that what you went through was really hard and not pass that on to the next generation of psychologists and be like, oh, well, I had it hard, and so I'm going to make you suffer too, because I had to and have to do that.

Melissa described her experience with messages to keep "pushing through" pandemic stress:

> Everyone has this mentality that (mental health is) something you just push through and mental health isn't something that you push through … You would never tell someone who was having a bout depression or schizophrenia "Oh, just push through and this will get better. All of a sudden, this will all be over." I think that's the way we've all viewed (mental health during) the pandemic for a long time.

Participants reported since starting graduate school, they have been spiraling downhill. They have described it has been hard to manage mental health. Hannah stated that "it's been hard. It's been really hard." Participants noted that there were times when they barely kept it together. They reported their mental health was horrible. One participant described having to repress details of stressful meetings with advisors and faculty. Helen detailed her thoughts on graduate students experiencing hardships:

> I would hope it's not a global experience of graduate students struggling and dealing with all of this not so fun side of academia, but I think that it is common enough that a lot of people are going to relate to dealing with a lot of these hardships.

In addition to participants experiencing hardships, emergent messages of difficulty functioning to meet demands as well as thoughts and experiences related to capability to productivity were found. Participants reported having difficulty functioning and dealing with impairment. One participant reported that they could not balance being high functioning, capable, and compassionate while in graduate school.

Participants noted that their mental health affected their work. They reported not being efficient in their productivity. Some participants described having a hard time turning in assignments. They reported not being able to submit coursework assignments due to their mental health, which lead to meetings with faculty and remediation plans. Participants described how they developed panic attacks after being told to produce more. They reported feeling like they could not keep up and as though graduate school was a juggling act where everything was falling all the time.

Participants described having very high standards for themselves and being very critical of themselves. They also described themselves as rigid, regimented, and strict people. One student mentioned that it felt as though if they were less rigid then it could jeopardize their goals. Additionally, participants mentioned they were hyper-controlled people. On the other hand, another participant mentioned feeling as though they had a lack of control of their surroundings. Despite this, other participants conveyed messages of hope, stability, recovery, and participants generally feeling good.

Some participants even reported that their mental health has been good and that they were not as distressed in graduate school compared to when they were in high school or college. Other participants described that, in general, they felt better during their first year rather than later during graduate school.

Other participants discussed how their mental health improved at times during graduate school. They reported that they developed coping skills as school years continued, and so their depression improved as they got more used to graduate schools' demands and expectations. Some participants also stated that they felt better after matching for internship and when they considered future employability opportunities.

Some participants explicitly stated that they were hopeful for the future, especially for their mental health to improve. One participant reported that their mental health was not even great or bad but rather "stable." On the other hand, another participant mentioned how they felt as though they were not mentally recovering. Syndey reported: "I don't feel like it could get much worse… I just have to believe that it could get better."

Participants conveyed their values, regrets, and changes in personhood that occurred throughout their survival of graduate school. Participants dived into feelings of introspection and their own insight. They discussed evolving values and priorities throughout graduate school. One participant stated that they put their mental health second compared to their school and career goals.

Participants additionally reflected on potential regrets. Participants highlighted their fear of regret with the path they have taken. They mentioned they did not know if they would take the same path again. Another participant, however, mentioned that they did not have regrets and would not do anything differently if given the option.

Lastly, participants discussed the impact of their journey through graduate school as a person. One participant explicitly stated that they felt as though they became a different person

going through graduate school. Participants described how easy it was to lose oneself and become a different person.

One participant discussed the ramifications of working towards changing the culture of the program versus just surviving within the program. Another participant reported that they had been focused on surviving, which did not include improving their mental health. Yet another participant described entering "survival mode" when it came to maintaining coursework obligations during the initial COVID outbreak.

Separation of Identity Subtheme

The last subtheme is Separation of Identity. Participants shared their experiences of how they did not live congruently with all of their identities. Participants shared their reasoning for participating in this project, which included a climate of separating a core part of their identity from the other versions of themselves in public. They felt that it was important work to highlight graduate students' with lived mental health experiences. Some participants felt it was the first time they were represented within research. As S described: "I think that it's important work, and I thank you for amplifying the voices of graduate students, because I think we get lost in the mix a lot."

Participants discussed how the topic of graduate students experiencing significant mental health concerns was not readily discussed even within graduate spaces. Melissa reported:

> I think it's really cool that you're doing this research because I think in my personal experience, these are conversations that are whispered in hallways, very much like you have to fight to find out this information when it should just be public knowledge …

> I wish programs created more space for lived experience with mental health concerns … We never talk about lived experience with trauma, lived experience with anxiety, depression, even though we have practicums for people to work with these populations. We never talk about what is it like if this is also part of your own experience.

Libby described her passionate reasoning for participating in this project in order to build awareness for graduate students experiencing mental health struggles:

> (This project) is something that could help others. And I really just felt a passion for your project, and I was like, I want to be a part of that. And I don't care if some little identifier gets slipped. I think that the benefit outweighs the risk, and I think that within grad school and the culture of grad school and mental health, it's not talked about, like in my program, and it's like, oh, my God, here's an opportunity to talk about it ... I am going to be as honest as you need me to be so that you can take this and move it to the next level and bring awareness.

Hannah recalled how the project allowed her to highlight her experiences with mental health struggles when otherwise she would not be allowed to talk about it: “When are we called on to be authentic about that part of ourselves? Never, almost.”

Hannah went on to share her experiences with how she felt the need to be the part of herself that included her mental health struggles. She shared her thoughts about being able to be “all versions” of herself by taking part in this project:

> If I look too distressed or if I tell somebody I had a bad mental health day or I was feeling a little depressed … they might find me out. I don't even know how to describe it. I don't even have the words but it's almost like this weird fear of I've been hiding. And then

> when I saw your research ad, it was like, Oh, I don't have to hide. That's a space where I can just be all versions of me at once. It was like a wanted ad. And I was like, Me? Sure.

Advisor/Mentor Theme

The advisor theme is made up of subthemes regarding participants' experiences with advisors. There are two subthemes. The first subtheme is Quality of Experiences with Advisors. The second subtheme is Alignment/Fit With Advisor.

Quality of Experiences with Advisors Subtheme

Participants shared positive experiences of their advisor, which include messages of feeling supported, understood, and as though they were a good match with their advisor. One participant reported feeling good about receiving intensive and extensive feedback from their advisor, which highlighted that the advisor cared about the participant's research. Another participant reported that they told their advisor they were overwhelmed, and that the advisor responded respectfully. Some participants reported that their advisor was open to listening to the students' concerns and hearing about personal stressors. One participant stated that "my mentor is lovely." Another participant described their internship training director as open, nurturing, and transparent.

Participants highlighted moments where their advisor took action or spoke kind words showing support and kindness to students. One participant reported that their advisor advocated for them with fellow faculty members by telling faculty to lend some grace to the participant when they were facing hard times. Another participant described how a mentor purposefully removed certain responsibilities from the participant after the participant described how overwhelmed they were feeling. An advisor offered reassurance to another participant, by

explicitly stating that they did not regret taking said participant as a student after the participant confessed feelings of self-doubt.

Some participants reported that their advisors shared stories on how to practice work-life balance. Advisors reportedly told participants to “aim for 60% energy instead of 110% energy” to complete certain tasks. Participants reported that their advisor told them to stop doing so much, including to not attend optional seminars.

On the other hand, some participants described negative experiences with their advisor. Participants reported that their advisor was not listening nor understanding of students’ concerns or grievances. Some reported feeling as though their advisor was out of touch with students’ poor experiences in graduate school; especially in one case where the advisor said that when they were in graduate school, it was the best time of their life. Joshua commented on advisors’ expectations of managing workload and work-life balance.

> I know (an advisor who) said, if you're not working 80 hours a week, you shouldn't be in graduate school ... And (they’re) like, oh, yeah, you need to have work life balance and all that. It's like, well, you apparently don't think that.

Another participant reported that when they started to take on more responsibilities outside of the research lab, tension grew with their advisor. One participant stated how they believed that their advisor did not care about them as a person. Multiple participants reported not feeling supported or validated by their advisor. Mackenzie described her advisor’s reaction to a rupture in the mentor-mentee relationship: “It felt it genuinely felt like he just wanted to chastise me. He just wanted to punish me. He was angry with me and wanted to discipline me. That's absolutely how it felt.”

Participants additionally noted messages of power when it came to the negative experiences with their advisors. Joshua described his peers' experiences with their advisors in graduate school:

> There's a lot of people who have much more critical, harsh, demanding, unforgiving (advisors). (Advisors) mean so much when you're in graduate school only because that's who's giving your training, but that's also who has control over pretty much everything that you're doing.

Skipper emphasized the power imbalance between advisors and graduate students and its impact on graduate students:

> I feel like now it's just this authority figure that is dictating every domain of your life virtually that you cannot say is a boss, you can't say is a friend. You can't really define a mentorship relationship. It's kind of vague and it can make you question what your autonomy is and the process. Maybe programs overemphasize handholding in the early stages. That's something that did not work for me.

Participants additionally described instances where their advisor did not demonstrate acts of kindness or support in situations where students desired such responses. One participant mentioned that their advisor does not give advice or recommendations. Another participant reported that their advisor does not defend them. One participant reported that their advisor stated that they would not fill an emotional support role for the participant. Another participant reported that their advisor will check in with other students about their wellbeing but not to their own students working under them. One participant mentioned that they did not think their advisor could provide needed comfort due to cultural differences.

Participants additionally reported on messages regarding boundaries that they learned from their advisor. Some participants reported their advisor modeled a good work-life balance, which let them feel as though they could also lead a work-life balance as a student. Other participants described their advisors as working heavily, with one participant calling their advisor a workaholic. Another participant reported that they felt if their advisor was working, then they should also be working. Sydney described:

> … (A) message that I got from that was to be a tenure track faculty member or to be another form of successful person that I look up to: You, by definition, almost have to have poor self-care, poor work life boundaries, at least for part of your training.

Nichole shared a similar sentiment with: "I don't think there's ever been a period of time where I've been able to not work evenings and weekends."

Participants had many examples of their advisors working heavily. Hannah described her advisors' work-life balance:

> My advisor, for instance, she's on all the time. She doesn't expect you to be on, but she's on all the time. She went on vacation and she disappeared for three weeks. We didn't hear from her, but now she's back. So she's on again. So everyone has their different way of doing it. But I feel like they get it in.

Several participants mentioned their advisors emailing academic related messages while the advisors were on vacation with their families. S shared about an experience receiving text messages from their advisor while S was on vacation: "I've shared that I thought it was very inappropriate getting text messages while I was on my vacation. And my advisor was like, okay, well, I guess I won't do it again."

Participants also reported that their original advisors ended up leaving academia due to the crushing workload expectations that impeded spending time with family.

Nichole described struggling with relationship boundaries with her advisor: “There was a lot of weird boundary blurring and complaining from (my advisor) and wanting support from me in this way that I was fully not equipped to give.”

Alignment/Fit with an Advisor

In the subtheme, Alignment/Fit with an Advisor, participants described the importance of the alignment or “fit” with an advisor due to the extensive impact an advisor has on graduate students’ careers. Participants emphasized the power of the advisor-mentee relationship. Hannah noted her beliefs regarding the relationship between the advisor and graduate student:

> Probably the most important thing in my opinion is the mentorship relationship. I know all programs are different, but mine is a very heavy, strong mentorship model where (my advisor) pretty much is holding my hand through this whole thing … I just feel like if my relationship with (my advisor) looked different, my mental health honestly might look very different.

Participants reported valuing a validating and caring advisor, to the point where it was highlighted to consider the interpersonal reputation of a potential advisor when choosing a graduate program to attend. S described her wants from an advisor: “I wanted to have an advisor that I would be comfortable sharing information with and that would be validating of that.” However, some participants reported they instead valued professional and cordial relationships with their advisor, with more firm boundaries between the professional and the personal. For instance, Hannah stated: “I don't know if this is a Latin American thing or it's just a me thing.

But I just don't like to mix my professional relationships with my personal life." Above all else, participants stressed the importance of the advisor and mentee relationship; participants warned how students' experiences of graduate school depend on the relationship with the advisor. Nichole emphasized said statement: "I would say be super picky about who your mentor is because I think that that really makes or breaks your experience."

Participants described their experiences with various changes involving their advisor. They differed in their perceptions of switching their original advisor with a new advisor; some participants reported that it was common to switch labs or mentors. Other participants reported that leaving your original lab could lead to gaining a poor reputation. Participants additionally described advisors' unwillingness to change their thoughts or behaviors. Some participants reported that they had to accept they could not change their advisor and accept them for how they were.

Participants described the experience of expressing emotions in front of their advisors and their advisors' reactions. They reported that they cried in front of their advisors, with one participant expressing embarrassment for the action. One participant expressed a fear of crying in front of their advisor. Another participant reported that they were afraid to be emotionally expressive in case their advisor judged them to be immature or unprofessional. Skipper detailed a moment when graduate students learned what sort of expressions faculty expected of them:

> I remember there was a professional colloquium of sorts and (faculty) said, "no matter what happens, we want you to come smiling." Just having you … be like (a) super person robot. That was the message that I got. That was the message that we got. And that felt like a lot of pressure, I remember. Straight out the gate.

Disclosure Theme

This theme is made up of subthemes related to the acts of disclosure, specifically regarding disclosing mental health experiences to others. There are three subthemes. The first subtheme is Disclosures from Faculty and Programs. The second subtheme is Student Disclosure Experiences. The third subtheme is Beliefs of Disclosures.

Disclosures from Faculty and Programs Subtheme

In this subtheme, participants described their experiences with hearing mental health disclosures from program faculty and others in positions of power. Participants reported wanting to hear their mentors be honest about professional struggles and challenges when it came to managing mental health of professional demands. When faculty discussed their own experiences with graduate school, Sarah was left wanting for more information. Sarah reported that faculty have said "Yes, grad school was hard. It was stressful. And that's the end of the conversation." However, there can be negative consequences if the faculty member overshares. One participant reported that they knew of a friend who became overwhelmed and ended up switching labs after their advisor self-disclosed mental health history and current struggles.

Some advisors reportedly alluded to having their own mental health journey and treatment. Some advisors and faculty reportedly self-disclosed having difficulties with burn out. One faculty member reportedly was open about experiencing depression, and they are well liked by students in the program. Another participant reported that a faculty member disclosed a significant distressing mental health event. One participant commented that they had an advisor who occasionally self-disclosed mental health experiences. Hannah described her own experience with her advisor offering self-disclosures of suicidal ideation experiences:

> … (My advisor) did mention to me her own experience … A, with herself and B, with family members and C, with other students. So, she had normalized (suicidal ideation) to a point of like, it's like any other thing that can come up in one's life that you might need support. That's how I feel about it with her.

Participants reported seeing psychologists making a public statement in an article that they have struggled with mental health experiences. One participant stated that a non-clinical faculty member disclosed having obsessive compulsive disorder. Additionally, participants described that faculty discussed disclosures, specifically, of other people. One faculty member reportedly brought up Marsha Linehan's disclosure of having borderline personality disorder in class. Sydney described that those in positions of power should be the ones to self-disclose first. Syndey stated:

> … The biggest stars in the Me Too movement should be the ones to be willing to disclose first. Like the ones with the most power should be psychologists that I'm sure we all have heard of and admired. Self-disclosing is really meaningful.

Participants also pointed out that self-disclosure from faculty does not necessarily lead to participants feeling comfortable to self-disclose.

Participants additionally reported on their experiences with faculty and others in power *not* providing self-disclosures on their mental health experiences. Some participants reported that faculty never self-disclose, and they especially do not share their own mental health experiences with students. In fact, one participant's advisor was reportedly purposeful about not self-disclosing to students. S reported that "I've also had conversations with my advisor in which she has said that she purposefully doesn't talk very much about what's going on in her life." Clinical

faculty were reported to avoid self-disclosures. One participant mentioned that a faculty member with a visible disability never mentioned it. As Nichole mentioned: “It’s interesting to me to think about all the faculty in my program who have struggled but are struggling and just don't talk about it. And so, I just think everyone is feeling really alone.”

Another participant pondered that faculty seem to be waiting for the perfect moment to self-disclose. Sydney wondered: “Why are all these faculty members holding out on us as students to not disclose until the right time? (Why) not create a culture where that doesn't seem like a huge disclosure, to share that information.”

Participants described the messages they have heard from their program and faculty regarding encouragement of students to self-disclose. They reported experiencing pressure to disclose mental health symptoms to fight against the stigma of doing so. Participants described there was no perfect time for disclosure. Reaching out was reportedly not considered to be a weakness by participants. MC described her experience with encouraging messages to self-disclose mental health issues:

> The (Director of Clinical Training) was pretty open and very nurturing and very transparent about the process and I think really encourages, like, a culture of, like, being open about if you're struggling and really encourages everyone to kind of see the humanity in in everyone else instead of, like we're always just trying to be productive all the time.

Meanwhile, Skipper’s program reportedly also encouraged self-disclosure of mental health to the program but namely for ethical reasons instead of in aiding support from others. Skipper described:

> I've heard, you need to disclose to us as soon as possible, but it didn't feel like you need to disclose to us and we will support you through it. (Rather,) you need to disclose it to us because it's unethical to deal with it and it's going to probably have consequences for your performance here. That's how we heard it.

Participants reported that they wanted to share what was going on with them to their advisor. One participant reported that they believed their advisor would want to know that they were experiencing suicidal ideation. However, it was reportedly recommended to make sure that you trust the people you are disclosing to. Participants mentioned that the university's counseling services were private and will not get back to professors.

Participants described messages they have received that do not support student self-disclosure. They conveyed that mental health amongst graduate students was not discussed. Other participants reported implicit and explicit messages that graduate school was not the time nor place for self-disclosures. Students were given the message to keep the personal issues out of classes and their schooling. In classes specifically, students were told that it was not the place to discuss their past, but rather, a place to focus on learning.

Participants additionally pointed out that there was a lack of communication on expectations of self-disclosure. Some professors reportedly explicitly stated that they do not want students to self-disclose personal mental health information at all. Sarah described that one faculty member stated "you know that you come into this field because you have your own personal problems, but you don't talk about that." Libby described her experience at graduate school orientation when the topic of self-disclosure arose:

> During my orientation to the program, the director of the program said, “Do not talk about any of your issues. Leave your private life at home. School is school. You're here to work.” And so, it was told to us, you leave your private life at home. When you're at school, you're at school. So, it was clearly stated that this is not the time or the place to be talking about that kind of stuff.

Some faculty reportedly wanted minimal to no information from self-reports from students. One supervisor reportedly stated that students should only self-disclose if they are symptom free for several years. In fact, students were reportedly informed to only share personal details if relevant. Near the beginning of the COVID outbreak, one participant was told by their advisor to not self-disclose; S described such an experience with their advisor:

> … Pretty early on in the pandemic … (my advisor) was like, “it's probably best not to share what's going on in our personal lives with each other right now.” And I was like, what do you mean? You're the person who's supposed to be helping with my training plan and things like that. I want to be able to share things with you when it is going to affect my productivity and potentially when I'm meeting milestones and things like that.

Participants reported that they do not know how faculty will react to a self-disclosure. Some participants described that faculty were not safe people to provide a self-disclosure. Other faculty reportedly became uncomfortable if students self-disclosed. Participants assumed supervisors would likely find student self-disclosure annoying.

Additionally, there were messages that it could be dangerous for students’ standing in graduate school as well as their professional careers if they self-disclosed. Participants were

reportedly encouraged to wait to be in a position of seniority before self-disclosing, to protect themselves.

Student Disclosure Experiences Subtheme

This subtheme showed how participants differed in their experiences with disclosing amongst academic peers, their program, and as therapists in training. Some participants reported that they have not disclosed their mental health history nor when they are struggling with stress to their respective cohorts. One participant reported that they are close with their cohort, but they have not disclosed their diagnosis. Another participant reported that they would not tell their graduate peers if they were struggling. Some participants acknowledged that they would not disclose the severity of their mental health struggles to their cohort. Another participant mentioned how they do not mention mental health struggles at all with their cohort.

Other participants described instances where they have shared with their graduate peers about their mental health struggles, particularly when it comes to experiencing anxiety. In fact, participants reported that students tended to reciprocate disclosures amongst themselves. Libby reported that “I've had a lot of the students come to me and be just like, fall apart. And it's like, okay, well, let's talk about it. Let’s utilize our resources.”

One participant reported that they will tell their peers they have experienced mental health issues; however, they will not turn to their peers if they are in distress. Still, participants reported that they will share their mental health history with peers and have, in fact, disclosed their diagnosis to at least one person within their cohort. Sydney described her experience with self-disclosure amongst graduate students:

> When many of your friends are in grad school, most of your in-person friends are therapists. It's really supportive. We have a lot of listening skills. We have a lot of validation skills. Being very close to my lab mates and to this person who was not my lab mate and was not in my cohort, I think was really helpful and validating. None of the people that I've disclosed to didn't reciprocate or initiate disclosures of their own of their own mental health stuff. So, I didn't feel othered.

Additionally, participants reported that they have heard other students provide self-disclosures, including clinical peer supervisors. Joshua described his experience with self-disclosure when it came to reflecting on clinical practice:

> It usually has to be the students checking in with each other to see: Are you getting help you need? Are you able to process this? Are you able to do something after your session to help process what just happened? Rather than the supervisors about that kind of stuff.

Participants reported that they have disclosed their mental health experiences and sometimes even history to their program, faculty, and/or advisors. They have additionally disclosed to their advisor about their mental health history. Lola described her experience with self-disclosing to an advisor after falling behind on some projects:

> There was one instance where I was struggling and it's rare for it to let it really affect my work … I was slightly behind on getting something back to my advisor, and she wasn't happy about it. She (said) "I don't understand why you don't have them back. Is something wrong with your personal life or something?" And I (said) "Oh, I have been struggling a little bit." And then she (responded) "Oh, okay, well, I understand." And we moved from there. So, it was just that initial response where I was like, well, that's how

> you're going to be approaching me struggling? I was like, that doesn't make any sense … Then you try to backpedal and then try to be supportive, but it just doesn't really work anymore.

Melissa shared her own experience with self-disclosure: “My faculty were really responsive once I reached my breaking point. I think it was just frustrating that I had to reach my breaking point.”

Sydney reported that she did disclose her history of depression to her advisor but chose to withhold disclosing her history of an eating disorder, due to fear of increased stigma for eating disorder diagnosis:

> … I disclosed then that I had been diagnosed with depression. I've never talked with her about my eating disorder history. I'm not opposed to it, but I feel like way more potential stigma for that than for depression. I feel like depression is kind of like a diamond dozen, especially my kind, where it's always present a little bit. It's not that bad.

Some participants framed their depressive symptoms as adjustment symptoms to faculty. Indeed, other participants mentioned it was better to use vague language, such as general stress symptoms, in describing symptoms, rather than provide outright disclosure on mental health that hinted at actual psychological disorders or impairment. Libby described her experience with self-disclosure during the COVID pandemic outbreak:

> … There were a few times with COVID where it was just like, you know what? It's too much. Everybody's dying. There's too much. I can't focus on writing this paper right now instead of having to turn it on Friday, can I have the weekend to work on it? And professors being like, “Yeah, that's fine. Take your extension.”

One advisor reportedly responded to a participant's disclosure by asking what the student needed from them. Another participant reportedly disclosed to their clinical supervisor about their previous therapy experience, which was described as a good and supportive discussion. Participants noted they will self-disclose to faculty outside of their own program's faculty. One participant reported that they self-disclosed their substance use history with an outside faculty member, but never disclosed it to their own program's faculty.

Additionally, participants described discussions in practicum courses on student mental health experiences which offered opportunities for student self-disclosure.

Participants additionally discussed the endorsement of self-disclosure within the therapy setting. Participants reported they were open with their clients. They reported that they told clients that they have dealt with personal depression or anxiety. Helen described her experience with self-disclosure in therapy sessions:

> If (a client) is asking "Do you know what this is like? Have you ever experienced this?" I'm not going to lie and say no. I probably wouldn't disclose details, but I might say: "Yes, I've experienced anxiety, or I've dealt with panic before. These are things that are familiar to me, but it's still an entirely different experience than what you're going through. So this doesn't give me authority on what you're going through, but maybe I can relate a little bit more."

One participant reported that they provided an appropriate amount of self-disclosure as a therapist. Joshua supported some separation between the client and the therapist, as he reported: "There is some level of separation that I think is helpful for clients and therapists, and they don't need to be sharing that much with the client if it's not needed."

Participants felt that clients seek self-disclosure to feel safe with therapists. One participant reported that clients seek self-disclosure from therapists to feel connected to therapists. Another participant reported that the use of self-disclosure leads to validation and provides support to the client. Guadalupe explained her experiences with self-disclosure in sessions: “What's the best way to disclose this information? I tell my kids, I use belly breathing all the time and I feel anxious. Even the parents, I tell them, I have to use reappraisal every single day.”

Beliefs of Disclosures

In the third subtheme of the Disclosure theme, participants described various beliefs surrounding disclosures, which include mixed views, beliefs of students choosing not to disclose, and beliefs of how student disclosure led to problems.

Participants reported that self-disclosure could be good or bad. Participants felt torn about their advisor when it came to self-disclosure. It was reported that it can be difficult to navigate differences amongst faculty’s view of self-disclosure. Specifically, it was difficult to navigate faculty who do and who do not want students to provide self-disclosure, as Joshua reported: “that's also been just a stressor of having to navigate which faculty actually wants you to tell them when things are not great and which ones don't.” Helen pointed out the power dynamic that existed between faculty and students due to students being evaluated. Helen explained that:

> It's definitely been hard finding that line between how much do we share because our faculty members are psychologists. They're people that work as therapists and counselors in their lives. But also, there's the power dynamic, and I am their student. They are evaluating me.

Participants additionally brought up how cultural differences might get in the way of students feeling encouraged to self-disclose to an advisor or faculty member. Hannah described that "my advisor is lovely. I know that I could speak to her frankly about mental health concerns. At the end of the day, she's a therapist." However, later Hannah described her reluctance to self-disclose:

> It's less about actually about stigma within the field and more about just cultural differences. She's a White woman and I'm Latina, and I just am afraid that she'll pity... Not pity, but her way of comforting me might not be what I want.

Participants reported they would feel more comfortable asking for support if they had physical issues, such as having chronic migraines or a physical disability. They worried that sometimes faculty could even change their mind after a self-disclosure. One participant reported that their advisor was only initially supportive after they shared a mental health disclosure, but that this support changed as time passed. Participants pointed out that it was a very vulnerable action for graduate students to self-disclose. Helen reported that "(Students have) seen bad reactions (for) students who had suffered for saying too much or not saying enough" when it came to self-disclosure.

Participants described how there are different power dynamics in self-disclosure when it comes to disclosing as a student within a program versus when acting as a therapist providing self-disclosure in middle of a session. While in the role of a therapist, participants considered that it was important to consider the clinical needs of the patient when it comes to self-disclosure. Participants reported that they should be cautious of self-disclosure with clients. They noted benefits to therapists offering self-disclosure in sessions, and therefore, they recommended it should still be taught how to appropriately provide self-disclosures while in sessions.

On the other hand, participants described having not disclosed their mental health history, lived experiences of trauma anxiety and depression, depressive symptoms, and suicidal thoughts to faculty, advisors, internship supervisors, or mentees. Participants reported not having the desire to self-disclose in the graduate school setting. One participant reported the belief that it was rare for students to disclose struggling in graduate school. Another participant stated that they "can't even imagine disclosing the truth to faculty." Yet another participant described that they focused on providing updates about outside stressors and discussed those, instead of their own mood and functioning.

Some participants reported that they wished to disclose to faculty or their advisor; however, they did not feel comfortable doing so. One participant reported that they did not believe it would be helpful to disclose in their program. Another participant reported that they assumed their faculty already knew they were experiencing anxiety symptoms, despite not disclosing such information. In the role of a mentor, Sydney described her own experience with not self-disclosing to students, yet normalizing mental health experiences:

> I think I feel more professional responsibility to model some kind of change, but I don't know that I do that in any meaningful way with the (students) that I mentor now. I've never disclosed anything about my mental health to them. I think I speak about mental health in a way that might I don't know, … I assume most people in psychology have had their own mental health histories.

Participants additionally described fearing consequences of self-disclosing that would lead to additional evaluation and "check-ins" from their programs. Hannah reported that "I would hate to ring the alarm or have somebody have eyes on me because I told them I was

feeling depressed one day." MC described students' fear of self-disclosure that could lead to negative changes in perception of participants:

> My cohort doesn't feel like the faculty are safe places to disclose to about these things - that there's always some punitive element to it. They watch you even closer. If you identify as someone who's struggling, we're already watched a lot in the program, and they're even more checking in. And it's almost embarrassing. You don't want to be that person who's just thinking you need to be constantly checked in on and you need constantly to manage to make sure you're handling it because you don't appear to be handling it. You don't have your shit together and you don't have your life together. And your advisor has to check in on you constantly to make sure you're not falling apart. And so there's this stigma of you're an independent adult who can get their shit together and done.

Participants additionally reported having concerns about privacy if students choose to disclose to their program and university. Some participants said that they did not want to discuss such personal matters with faculty and preferred to not be too close to other professionals. Nichole described the impact of this on students who might otherwise use accommodations: "I know a lot of grad students who need accommodations (but) don't always use it because it requires disclosing in a way that I think they're uncomfortable with."

As such, participants have reported the belief that self-disclosing leads to problems. They worry about sharing too much and then losing out on opportunities. Additionally, participants have heard of other students' self-disclosing who then having reduced or limited opportunities of continued research or academic work. Another participant heard that one student's advisor ended up dropping them as a student after the student self-disclosed.

Additionally, participants have opened up to faculty only to be disregarded or not taken seriously. S shared about their experiences with disclosing that were meant with lukewarm responses “A lot of the times when I had before shared things, it was just sort of met with okay, and what are you going to do about that sort of thing? ... It was just not very productive or validating.” Guadalupe shared her experience with disclosing to her advisor who was not supportive:

> (My) advisor was like, “Why are you telling me this?” She said that verbatim. “Why do you think I should know this?” And I was like, because we're going on this journey together. So since then, she and I have not had a great relationship.

Participants described how they have disclosed but then not been given accommodations. They noted how it is hurtful to not get support when really need that support from faculty. It is uncomfortable to go through the self-disclosing, especially to admit to struggling right now. Libby described her interaction with her advisor and faculty following her husband’s suicide attempt: “The most that they ever did was (ask) “Do you have somebody to talk to?” “Yes, I do.” And then they're like, okay, we're absolved of anything.” Libby described her interaction with her clinical supervisor after she canceled her scheduled clients following her husband’s suicide attempt. She was told: “Don’t make a habit of (canceling clients).” She reflected on said experience:

> I was just like, in my mind, screw you. I can't meet with clients right now … Our ethics standards said, if you cannot meet the demands of this job, don't do it at that moment in time. And so I was just like, in my mind, middle finger, screw you, I'm (canceling the sessions) because this is what's best for me and my patients.

Participants reported that they have disclosed but then their disclosure information has been brought up to the training committee without consent. They reported having a feeling that anything students say can be turned against them. It was reported that faculty have complained that one student was too open with self-disclosure in class discussion. Guadalupe shared her reaction to being reprimanded for self-disclosing during class discussions:

> I'm very open. That's one of their complaints is I'm a bit too open at times. Like, grow up. I can tell you about how I was depressed in fucking undergrad. That has no bearing on my participation in this class. But I'm giving you a fucking, what's it called? A case example. What difference does it make if I say, oh, I knew someone as opposed to, oh, yeah, this is just who I am. I feel like there's stigma around mental health here.

Participants described stigma of being a therapist and having to self-disclose.

Another participant reported regretting a class disclosure, after they found out other students and faculty were uncomfortable with self-disclosures in professional settings. It was assumed by students that it could be especially uncomfortable for others if students self-disclose having more severe diagnoses and/or suicidal ideation.

Participants reported that faculty also pressed for more information regarding self-disclosure than students felt comfortable providing. They reported that they feared negative retaliation from disclosing too much or too little from their program. Participants worried that if they self-disclose that they will be scored poorly on their self-care.

Participants reported that they were afraid to be treated differently if they are open about their mental health. They described that there was a stigma of not being an independent adult if they self-disclosed that they were struggling or had a mental health history. Participants reported

that they feared they may not be perceived as having it “all together”. They also reported that they do not want their supervisors to believe that students want their supervisors to take on the role of their therapist.

Participants described there being a punitive element to when students self-disclose to faculty. They reported that faculty are unsure how to create a culture where disclosure is not a big deal professionally. S shared about their cohort engaging in self-disclosure to faculty about struggling with workload: “When me and the previous graduate students have expressed concern over the workload, we were met with defensiveness and an unwillingness to talk. (Faculty) just sort of shut down the conversation.”

After self-disclosure, participants reported that faculty may excessively check in with the student. Participants described worrying that their advisor would be too nurturing if students came out about their mental health journey. They reported that after self-disclosure, they are watched more by faculty. Participants described feeling embarrassed after a self-disclosure to faculty. They reported that they did not want others to worry about them and did not want others to enact “weird” or intrusive boundaries with them.

Unique Relationship with Psychotherapy Theme

Participants shared their experiences with personally receiving psychotherapy, providing psychotherapy as a therapist and a wounded healer. It has three subthemes. The first subtheme is Personally Receiving Psychotherapy Treatment. The second subtheme is Providing Treatment as a Therapist. The third subtheme is Wounded Healer.

Personally Receiving Psychotherapy Treatment

Participants described being currently in therapy as a patient. Some participants reported that they had ongoing therapy since after undergraduate school. One participant reported that they saw a community therapist who matched their identities. Some participants noted that they see their therapists several times a week. Other participants reported taking medication treatment as well for anxiety and depression. Some participants described how they found therapy to be more helpful in managing their symptoms than medication.

Several participants reported previously being engaged in therapy before graduate school. Participants reported that they received therapy through their university's counseling and psychological services program. Some participants described how they met with therapists for only a few weeks since being in graduate school. Other participants stated that they have been in therapy since starting graduate school. Some participants described how they have not found a good match with a consistent therapist. Participants reported they have seen community therapists for racism-related stress. Clinical psychology graduate peers were reportedly providing community therapy to each other.

Participants discussed their experiences of being treated. Some participants reported that they did not have good experiences as clients receiving psychotherapy treatment. One participant reported they did not have a good experience at their university's student counseling center prior to starting graduate school. Another participant described how they had a therapist drop them as a client. Yet another participant conveyed that they did not do meaningful work with their therapist.

Participants described various obstacles that could occur when it came to students' engagement in psychotherapy as clients. Some participants claimed that weekly therapy was not

attainable to manage with the graduate school schedule. One participant described how hard it was to find time during the day to get to therapy. Another participant recalled that they knew a peer who drove three hours for their therapist. Nichole discussed struggles that came with navigating care: “There were students talking about how difficult it is to navigate systems of care while you're in grad school and the cost and moving and changing specialists.”

Participants also shared concerns over the cost of services for psychotherapy. They reported not being able to afford therapists, even when offered sliding fee scales. S shared more about the nature of sliding fee scales on a graduate student budget:

> Even with sliding scales, a lot of them don't go down past $20, $30 an hour, which is still very generous. But when you're just supported on your income as a student, it's still not very doable … (That is) half of what I pay for groceries every week.

Participants reported wanting access to therapists. It was suggested that graduate programs should have supportive mechanisms in place for students to be able to receive therapy treatment. This was particularly relevant, given that it was reported that therapy that was available was not attainable due to the therapists’ connections with the graduate program. Therapy groups that were reportedly offered to participants in general were not accessible to clinical psychology graduate students because of the group’s connection to the participants’ programs.

Participants described additional difficult situations that came from receiving therapy from a potential future practicum. They reported that they struggled with attaining psychological evaluations, as they had strong knowledge of questions and testing materials that came from

examiners. Lastly, participants noted the difficulty in finding a therapist without connections to the program when the program is located within a small town.

Participants reported on messages from their program that they received about students receiving therapy. Participants noted that their faculty generally did not discuss the advantages of previously attending therapy. However, one participant described that their faculty briefly mentioned that therapists who previously were a client functioned better as a therapist. Indeed, some professors appeared to have given messages that it was okay for students to disclose that they had been in therapy before, but not to disclose any received diagnoses. Still, participants reported that while it was normal for others to go to therapy, it was not normalized for students to attend psychotherapy treatment. On the other hand, participants still talked with their friends about their own therapy experiences and received encouragement and support to continue with therapy treatment. Graduate school peers reportedly recommended starting therapy before problems began in graduate school.

Participants reported that being in therapy was helpful when it came to coping with graduate school. They appreciated being able to process graduate school experiences with their therapists. With therapy it was reportedly helpful for participants to learn how to establish boundaries between work and their personal lives. Libby described her experience with therapy where she established boundaries and reevaluated her self-worth: “(My therapist) really helped me to just be like, no, you don't have to kill yourself to show that you have worth. You can have (worth) and not kill yourself.” Meanwhile, Mackenzie described her experience of being in therapy and how it salvaged a working relationship with her advisor:

> Ultimately, I think, and my therapist helped with this, I just had to reset my expectations for (my advisor) and accept what he could offer me and then just accept that he was not

> going to be someone I wanted him to be. (I) just (had to) see him for what he was and appreciate him for what he was… We're a lot better now but it took a lot of time.

Participants described how having previously been in therapy allowed them to be better in tune with the emotional states and needs of themselves and others. Students' therapists reportedly helped to establish new core beliefs. Therapists also reportedly helped to increase participants' engagement in pleasurable activities. Participants described how therapy aided students to return to being functional and feeling good. Sydney discussed the great patience and grace she received as a client from her own therapist, which was very meaningful to her:

> I think about my own experiences (in therapy). The therapist that I had when I started really recovering from my eating disorder was fantastic … If I were my therapist during that time before I really committed to recovery, I would have wanted to wring my neck … Like, I was so annoying. I wasn't annoying; I had an eating disorder. It was very hard. I'm sure that it was frustrating to work with me at times, and I'm sure that it felt like no progress was being made because I was on paper trying to make progress. I had a dietitian; I had a therapist. I was really quote unquote, trying. But if you talked to me and really got to it, I was not trying. But then I did (try) … Thinking about that patience and grace that I received as a client, (it was) very meaningful to me.

Participants described how previously receiving therapy allowed them to become better therapists. They believed they were better clinicians due to having gone through therapy themselves. Participants believed that individuals who had a history of psychotherapy treatment were more intuitive, and connection-focused in their own practice of psychotherapy treatment. Previously being in therapy was thought by participants to additionally help to cultivate empathy for their clients.

One participant recalled an experience with a peer who never went to therapy as a client; the peer reported being jealous of the participant for the seemingly good effects it had on their clinical work. While in classes, students reportedly were able to make connections to their own therapy experiences. Sydney recalled how her own previous psychotherapy provided greater insight into how a client feels during treatment:

> I think that that is really useful to kind of remember what it's like to be waiting in the waiting room, to be asked probing questions, to be treated maybe like a number or like a diagnosis rather than a whole person … I think all of those things help me have more compassion and patience (as a therapist).

Providing Treatment as a Therapist

The Providing Treatment as a Therapist subtheme examined participants' experiences while learning to be psychologists and practice psychotherapy and assessment. Participants reported on their relationships with clients, specifically how they viewed the relationship within a therapeutic setting. Hannah reflected on such an experience: "It feels like a privilege to let people let you in and observe people's lives." Participants additionally wondered if clients picked up on participants having their own mental health journey.

Participants regarded aspects they liked about clinical work. Most participants reported that they enjoyed providing therapy and wanted to continue to engage in clinical work. Some participants described clinical work as having instant gratification compared to academic work.

Participants reported that it felt good to be in a helping role and doing something for someone else. Melissa described the unique impact of providing services: "Doing clinical work really was illuminating and (it) applied that level of humility and care that I had been wanting in

a lot of the other things that I was doing in my graduate work." Several participants described it being nice to be the person with answers. Some participants felt called to substance use recovery work in particular.

Participants were reflective of their own therapy process. They reported that they were there to help others because of their own challenges. Practicing as a therapist, participants described, shined lights on participants' own areas of growth. As Melissa stated, "there's something about actually being a clinician and working with someone in therapy that helps really illuminate some areas of growth for yourself." Participants additionally described how they found ways to help themselves when they worked with clients. They reportedly became more confident in the current clinical skills. However, some participants expressed that they still experienced imposter syndrome when practicing therapy.

Participants emphasized that therapists did not need to have had their own mental health struggles to help their clients. Several participants were adamant that therapists brought something unique into the therapy room with or without having their own diagnosis. Participants additionally pointed out that people have individual healing journeys and therefore, students' own healing journeys were likely different from their clients. Some participants discussed that it was better as therapists to "step back" than over identify when providing treatment. It was deemed helpful to have some separation between the client and the therapist when doing therapy. Sara reflected on her own thoughts when it came differences between individuals and their healing journeys and how that impacts her work as a therapist:

> I don't know how useful necessarily my own experiences have been in trying to help others. I think sometimes it actually just gets in the way. Not in that because I'm so stressed or because I am experiencing difficulties (or that) I'm a worse provider for it,

> although that is occasionally the case, honestly. But in that the way that I've experienced mental health and healing throughout the process and the ups and downs is not the way that other people do it. And I think that at times when I have drawn too much on my own experiences, it has been like, eclipsed the presentation and the things that I'm actually hearing from patients. So, I think for me, stepping back has been helpful more so than over identifying.

Participants described the prevalence of empathy within their treatment work. Participants described having much empathy for their clients. In particular, participants' own lived experiences of mental health enabled participants to provide more empathy and understanding of their clients' lived experiences. However, other participants pointed out that a person may be able to empathize, but they could not viscerally conjure the same feelings of their patients, due to differences of life events.

Some participants reported that their own experiences have not been helpful in providing treatment. One participant could not say that their mental experiences make them better at doing therapy. In fact, it was reported that students' own struggles could get in the way of effectively helping clients. Participants reported that they had consider if they were in a good mindset to work with clients. They noted they made sure to honestly ask themselves if they were able to help or if they were hurting right now. Lola described how her own experiences may impact a therapy session:

> I'm going to be completely honest. If I'm currently going through a hard time and there are certain triggers that I have and that comes up in session, it's going to come up in session … I work really hard to not let it affect my session and my client but can I say (with) 100% certainty that it does not? No, I can't ... Do we all, regardless of having a

> mental health disorder or not, bring things into the room? Yes. So, is it so different? Maybe not.

Participants reflected on how their own experiences were helpful to the therapeutic alliance and treatment process. Their own experiences reportedly have brought in a different type of therapeutic alliance energy. Participants agreed it was especially useful to tap into the energy of their experienced struggle. Melissa described "it just allows just a different energy in the room or a different therapeutic alliance because there's a difference between reading about something and knowing about it." Additionally, participants' own journey was reported to help with doing therapy. Participants noted that they were able to pick up on certain language clients used that hinted at impairment or certain experienced symptoms.

Participants additionally felt as though they had gained more insight into sessions than therapists who did not have their own mental health journey. Libby reported that "we all know that we're here for a reason and that we are able to help heal others based on our own challenges." Participants reported that they could intuitively understand barriers to wellbeing. Nichole described her experience with empathy as being helpful as a therapist:

> I think that it definitely resonates with me, the idea of like, you've been in the trenches, you know what it means to struggle that much. You can have this empathy that maybe other people can't. You can inspire hope. I think that's a big role of the therapist in the beginning of treatment. And I think that you're just more effectively able to do that, if you remember what it was like to feel that way.

Helen also shared her experience with empathy when it came to panic attacks specifically:

> It's definitely been helpful to know what a panic attack feels like to know what that patient is going through. Because a lot of times from the outside, if you've never

> experienced it, you could look at someone and think, Oh, it's not that serious. It's going to pass. You're going to be fine. And it's different to say it will pass. You're going to be fine when you've also been through it and know what it's like to think it's not going to be fine and that it's not going to end.

Participants reported feeling more invested in clients and as though they were more normalizing of their clients' experiences because of their own experiences. They additionally felt as though their experiences helped with building rapport with clients. In particular, the participants' experiences strengthened the therapeutic alliance and allowed for more compassion and patience for clients.

Participants described that they felt more connected and understanding of their clients. They viewed clients were viewed in a humanizing manner, due to their own mental health journey. Particularly when it came to some participants' own history of eating disorders, they reported that they understood the difficulties of recovery from eating disorders in a unique way.

Participants described how they borrowed from their own personal therapy experiences. They noted that they came in with more skill because they had been in therapy before. Nichole reported that "I really felt like I was more prepared to be a therapist. I also think that it really helps in a lot of ways because I felt more in tuned to myself and I knew what was going on." One participant reported they came in better prepared to be a therapist because they had previously been in therapy. MC reflected on being a therapist who had been in therapy beforehand: "… Having done my own therapy, sometimes I borrow some things from that. And I think it gives me a different depth to my clinical work that maybe I wouldn't have if I hadn't experienced therapy myself." Another participant believed they were faster and more accurate with

hypothesis testing due to their own experiences. Participants agreed that their own experiences in therapy was helpful when conducting treatment.

Participants reported that they knew what it was like to be a patient in therapy and so they understood struggles with progress in treatment. They particularly believed they were more understanding of clients' lack of progress and difficulties that arose during treatment. Participants described that they were able to have open conversations in therapy about how hard it can be to implement and utilize therapy skills. They noted that they were mindful of how it does not always need to be action oriented in sessions. It was reported that participants were especially mindful of their approaches to treatment due to their own bad experiences in treatment.

It surprised the participants how emotionally challenging and taxing it can be to be a therapist. Participants described how they experienced feeling of lack of support navigating the transition to being a therapist especially when graduate school stress was deemed to be able to impact the quality of services provided. Mackenzie reported that "it is challenging being a provider whose own wellbeing is not carved out or protected." Participants affirmed they were working with patients while experiencing clinical symptoms themselves. They reported that there have been times when they have not been present in sessions due to stress-and anxiety-inducing events from the week. Participants reported that they have also had to cancel sessions following significant personal life events that occurred.

Some participants described how they felt that they are not "practicing what they are preaching" to their clients. At times, participants reported that their own history made it hard to provide services. Hannah described her own struggles: "I think perhaps just especially as I'm

training, there's this feeling of, who am I to help this person when I couldn't get out of bed yesterday?"

In fact, because of their own experiences, some participants practicing therapy found that therapy could be triggering for personal issues. Sometimes participants reported that they had their own triggers that have occurred during a therapy session. Several participants described how they preferred to practice clinically with clients who they do not identify with. Participants reported that they additionally found themselves to be struggling but not being able to locate accessible services for themselves. They found out that graduate participants were providing the low-cost services that they themselves need. As Helen describes:

> We are the ones that people go to for low-cost services. So where does that leave us? When we're graduate students, we're obviously not making a whole lot of money, so it does get really expensive. And I think that having some greater level of access or options for us, having those resources outside of a crisis line, which, of course, is so important, but not necessarily what the participants are actually needing in the moment.

Wounded Healer

The Wounded Healer subtheme reflects the discussion around the concept of wounded healers in psychological treatment practice, particularly as it applies to graduate students. Participants described the wounded healer description to "make sense" and as being "valid." It was also described as being accurate and participants completely agreeing with its definition. Participants reported that there was value in having wounds. They felt encouraged hearing about wounded healers. On the other side, some participants reported they did not like the name of the wounded healer. One participant reported that the title sounded prestigious and that they could not relate to it. Hannah reported not feeling "worthy" of the title. Another participant reported

that they did not consider themself to be a wounded healer because they did not provide services to people who dealt with similar issues to their own.

Still, other participants related to the idea of being a wounded healer. One participant described themself as a wounded healer in training. In fact, it was pondered that everyone was wounded in some way; therefore, participants suspected that most psychologists were likely on the spectrum of being a wounded healer. A participant predicted that 70-80% of therapists were wounded healers.

Participants felt that wounded healers were those already working within the field of psychology. They figured that substance use treatment providers already utilized a wounded healer approach to improve treatment outcomes. One participant reported that their supervisors showed how to utilize wounded healer components during treatment. Other participants' experiences revolved around not disclosing wounded healer experiences.

Participants described difficulties associated with wounded healers. It was assumed that people who identified as wounded healers may struggle with clients who have experienced sexual abuse and posttraumatic stress disorder as it may relate too closely to their own experiences. Another participant disliked the wounded healer concept as it created an idea of an "unwound healer", or a healer without wounds. One participant speculated that a wounded healer may additionally be considered a double-edged sword, so the positives and the negatives the concept brings end up being washed out. Additionally, the wounded healer concept was considered by some participants to potentially be more anecdotal in nature and not necessarily have a scientific foundation. Participants noted that it would be important for therapists to still recognize their own bias; just because a protocol or treatment worked for the therapist did not mean it would work for every client.

On the other side, participants argued for the benefits a wounded healer may bring to the field. Wounded healers were thought to be able to offer special experiences for clients. Participants suspected wounded healers would receive good reactions from clients. Additionally, clients reportedly may relate more strongly to their counselors who are wounded healers. It was believed that more effective therapists are wounded healers who inspire hope and engage in empathy. Participants believed that wounded healers may provide a different depth to clinical work than non-wounded healers. Additionally, it was pondered that wounded healers may have helpful insight into treatment adaptations. Still, other participants believed that the wounded healer concept was not necessary for therapy, but that it could still be helpful in providing treatment.

Resiliency Theme

In the Resiliency theme, participants discussed what gave them the capacity to continue graduate school in spite on the unique stressed they faced. There are two subthemes. The first subtheme is Coping Strategies. The second subtheme is Advice For Other Students.

Coping Strategies

Participants described what has kept them going so far in graduate school, even with all the stress, stressors, and mental health struggles they have experienced. However, participants pointed out that self-care activities were not going to be able to "fix it all." Still, they acknowledged engaging in self-care-like activities or coping strategies that they did find it to be useful managing their mood and graduate school.

The importance of other people as being keen motivators was mentioned by students. One participant reported that they were interpersonally motivated. Some participants reported

that giving to others kept them going. Libby described how motivating her experiences were where she helped others:

> Giving somebody the ability to just expand their world just a little bit is what keeps me going, because I've been in a place where I didn't think I could turn anywhere. Giving back is what keeps me going because it doesn't have to be this way.

Another participant reported that wanting to make their family proud kept them going. Yet another participant reported that it was the graduate peers that taught them how to survive in graduate school.

Other participants looked more towards the financial reasoning for continuing to stay in graduate school. One participant reported that they "put all my eggs in one basket." Other participants affirmed being a clinical psychologist was their chosen career path. Another participant reported that they continued to find the field of psychology to be interesting. Yet another participant reported that they wanted financial security in the future and another participant believed they would be successful financially in the future.

Other participants looked intrinsically for reasons to keep going. Several participants reported that their pride and stubbornness were the reasons they kept on going. Other participants described experiencing determination to finish their program and become clinical psychologists. Another participant reported that they had the belief that they can get through hard times in graduate school. Yet another participant reported that they had the mindset that they were willing to do anything to stay and complete graduate school.

Other participants took a more optimistic approach. They described having the mentality that graduate school was just a short period of time in their life, which they found motivating to

keep going. Participants were able to reflect on positive moments in the past, including “I made it” moments. They described being able to make the most out of their situations. Participants reported that they had just “hoped to god” that they could make it. They reported that they tried to be nonjudgmental and tell themselves that it was all going to work out and that things would become easier with time.

Socializing was a coping technique. Participants prioritized their relationships. They reported that they connected with other participants inside and outside of school to have time for socialization. One participant mentioned that others could give them objective information, which allowed them to challenge their negative self-thoughts. Participants additionally reported that they made a point to reconnect with family members and spend large periods of time with family during breaks. Another participant reported that they also adopted a cat to help cope with graduate school.

Participants engaged in meaningful and fun activities as another coping strategy. They purposefully engaged in fun activities. Participants worked on being more active and exercising. They engaged in activities such as cleaning, cooking, baking, woodworking, and watching TV shows. Participants reported that they also made a point to go to the park and go on walks. They also mediated and had personal dance parties.

Participants additionally reported that they worked on taking care of themselves. They specifically tried to be gentle with themselves and careful of their energy. Participants focused on being present. They also made sure to make special moments for themselves. Multiple participants identified the use of humor as a coping skill. They additionally talked about “powering through” the difficult times in graduate school.

Participants described the importance of setting work-life balance boundaries. One way to set a boundary was reported by students to make time for a personal life. One participant encouraged others to read the book Set Boundaries, Find Peace by Nedra Glover Tawwab.

Participants also relied on their own clinical knowledge. One participant described utilizing the downward arrow technique to be an effective coping skill. Other participants acknowledged the benefits of leaning into known protective factors. One participant reported that it was important to "evidence check" themself. Another participant reported that changing their medication was helpful.

Lastly, participants additionally discussed ways of managing the workload as a way to engage in self-care. One participant reported gaining benefits from reducing their workload from a side job. Another participant made a point to report that it was okay to back out of commitments to take care of themself. Participants additionally reported that if they are trying to work on a task but have not done anything after ten minutes then they will stop attempting the task and try later.

Advice for Other Students Subtheme

Participants shared advice for fellow and upcoming students on how to manage graduate school while having had previous or current mental health struggles.

Participants reported on advice regarding the decision to attend graduate school. One participant recommended that students eliminate programs based on location. Another participant reported that they would not recommend attending graduate school solely due to a person's identity and mental health struggles. Participants encouraged others to find a supportive environment that meets a person's needs and desires. Some participants shared that they did not

know if they would advise people to do a Ph.D. One participant described that it was not worth going to a program where they would be miserable the entire time.

Participants wanted others to remember their values. One participant reported that students should know the values they are bringing into graduate school. Participants additionally recommended having a clear sense of goals. They should additionally be able to advocate for themselves prior to graduate school. It was reported that students should, above all else, remember who they were before entering graduate school. Participants encouraged students to have a sense of what they are willing to do and what they are not willing to give up.

It was considered beneficial for students to set up/find good social support. Participants reported that students need to find safe people and places as well as people who are validating. It was recommended that students make friends with their cohort members. Helen described her relationship with her fellow students and how it helped her cope with graduate school:

> We're all working together and experiencing the same thing for the most part. So we're able to better advocate for ourselves and better manage some of those distressing things because it's not just me. That's one thing that's definitely been really helpful, knowing that I'm not the only one who's struggling. I'm not the only one who's dealing with some of the more stressful and certain things within the program. We're all dealing with it and we're all able to complain and joke and live it together.

Participants reported that they were reminded to treat all people with respect and dignity.

It was suggested that students learn and utilize the resources available to them. One participant emphasized that the students sometimes need to take the first step in getting necessary support. It was considered good practice to ask others for guidance on finding resources,

particularly university care coordinators, if available. Participants additionally reported that reaching out to ombudsmen could be beneficial.

It was recommended that one resource that students should utilize in particular was therapy. Many participants highly recommended that students seek a therapist to work with them throughout the graduate school experience. It was recommended to obtain a therapist as early as the application process for graduate school. Participants additionally pointed out that having a personal therapist was helpful for working through their own thoughts and feelings when it came to their own therapy training. One participant suggested that programs hire a psychologist specifically for their students, like how police forces hire their own therapists for its members.

Participants additionally shared advice regarding faculty and mentors. It was recommended that students should pay attention to the "fit" with their program and mentors. One participant recommended it was good to have many mentors. Another participant recommended that advisors should be kept at arm's length.

Participants reported that they would give the advice that there will be hard times in graduate school. One participant described graduate school as a "transformative, challenging journey." It was warned that students will not be able to go without injury. Participants reported that there will be negative feedback. They described incoming students should come in with the mindset that things will not go perfectly. MC described: "don't be afraid to seek services and to just acknowledge and accept that it's okay to be in grad school and also have these struggles." Several participants reported that they would tell their past self that graduate school would be hard but that it was something they could handle.

Participants shared messages around recommendations for setting boundaries while in graduate school. They highly recommended developing the skill to set boundaries before entering graduate school. Once in graduate school, it was warned for students to not overbook themselves for activities. Students should take care to purposefully engage in self-care activities and prioritize times for pleasurable activities during the week. It was encouraged that students have something for fun that was not associated with the program. Several participants recommended cultivating an identity outside of the program.

Participants provided some good reminders for other students to consider. It was recommended that students be cautious. They should watch, wait, and observe the people around them. Students should try to go with the flow, "chill out", and "slow down." Students were reminded that it was okay to not be so hard on themselves. In fact, they should remember that students can always try again tomorrow. Libby described: "Just realistically, what can I do? Where can I do it, how can I do it? Maybe it's not going to be today, but I can try again tomorrow."

Another reminder from participants was that they would not get kicked out of their program. One participant reported that if a student felt lost, that was okay. Participants encouraged others to engage in self-reflection. Lastly, it was normal for students to feel like things were not going well. MC described how to combat said feelings:

> It's okay to feel like it's not going well or that it's not okay ... It's how it's supposed to feel a little bit … It was normal for me and for other people to feel like I'm not doing something right. You probably are (doing something right). And it's just really, it's just like your capacity is (lower) and your demands are (higher).

Participants offered advice around the concepts of being proactive and adaptive with their needs while in graduate school. They encouraged others to listen to their body. One participant reported “to listen to yourself and your instincts.” Other participants discussed challenging overwhelmed feelings into something adaptive. Students were encouraged to identify what was not helping and then implement a fix. It was recommended to ask the self “what/how can I do it.” One participant reported that students should be proactive about getting help before things became too bad, especially when a person was experiencing suicidal ideation. It was reported that students should be direct with their current state and their needs.

It was encouraged for students to consider ways to improve their wellbeing by finding ways to reduce their workload from graduate school. One participant reported that graduate school should be treated with the mindset that it was a job and not school. With all the demands placed on students, students needed to come to terms with the fact that they would not be able to do everything well. Some participants encouraged others to not complete their full weekly assistantship hours. Other participants reported that students should not read all assigned coursework readings. Participants were reminded to not just volunteer for high stress commitments. It was recommended that students do not need to say “yes” to every opportunity offered to them and that they could, in fact, back out of prior commitments.

Summary of Findings

The results of this study were vast. Five major themes emerged from the data collected during the interview process. There was a total of 13 subthemes. Students described their experiences with emotional struggles throughout graduate school, naming specific symptomology and negative cognitive distortions that occurred as well as the experience of having to separate their identities. Students shared their positive and negative experiences with

their advisors, who were determined to be a significant part of the graduate school experience. Acts of disclosure were examined by students. Information about students' unique relationship with psychotherapy treatment was discussed. Lastly, reflections continued as students shared signs of resiliency for surviving graduate school.

Discussion

This qualitative study was conducted to examine the lived experiences of clinical psychology Ph.D. students who have experienced previous and current mental health distress. The study was limited to those students currently living in the United States of America. Findings of this study generally support previous literature on graduate students and clinical psychology graduate students which have stated that students face heightened stress and experience psychopathology (Hobaica et al., 2021; Siegel & Keeler, 2019). Graduate students in this study endorsed experiencing severe and distressing clinical level psychological symptomology and negative cognitive distortions while experiencing the highly stressful environment of graduate school. The qualitative questions asked during the interview provided rich data. It is assumed that this qualitative approach allowed for the voices of clinical psychology graduate students with lived experience of mental health struggles from across the United States of America to finally be heard.

The Heavy Emotional Experiences theme examined the experience of emotional struggles that participants faced while in graduate school. Within the Distressing Symptoms subtheme, participants experienced fluctuating moods. They developed anxiety and depressive symptomology. Participants faced feelings of grief and burnout. They identified experiencing imposter syndrome. Participants specifically noted that they felt as though they were in hiding and had a fear of being "found out."

Within the Struggling, Suffering, and Survival subtheme, participants' personal emotional reactions towards the impact of adjusting and living through graduate school were documented. Participants described experiencing negative feelings about themselves, such as being a failure and having self-blame. Pessimistic thoughts, feelings of defeat and thoughts that they "broke" in graduate school were discussed by participants. Participants additionally described having stress in the body. They discussed feeling overwhelmed. They pondered over suffering and debated on how it was or was not supposed to happen in graduate school. Participants described pushing through stress, particularly when it came to the pandemic. They narrated how they became a different person. They expressed being in survival mode.

Within the Separation of Identity subtheme, participants described their experience of living in a climate that did not allow for them to show and live their truths. They reported that they faced a separation of some identities involving their mental health journey when they were in public. They reported how there did not appear to be spaces for them to be their whole authentic self, as the climate around them dictated them to keep silent about their journeys with mental health.

The Advisor/Mentor theme regarded participants' experiences with their advisors. Participants discussed such experiences within the subtheme Quality of Experience with Advisor. Participants expressed positive experiences with their advisors and mentors. They shared that their advisors and mentors were supportive, understanding and responded well to feedback. Advisors and mentors additionally provided helpful feedback for students and shared work-life balance tips. On the other hand, participants described negative experiences with their advisors and mentors. Participants reported that advisors and mentors utilized a power imbalance within their interactions. Advisors and mentors were reportedly not supportive or understanding.

They also reportedly overstepped boundaries with participants. Lastly, participants reported that they modeled their advisor's work like balance.

The subtheme Alignment with Advisor under the Advisor/Mentor theme described the importance of the "fit" with participants' advisors. It was determined that advisors had a huge impact on graduate students' careers. As such, participants had many thoughts about the alignment with their advisors. Participants differed in their personal beliefs of traits wanted from an advisor. Some participants wanted an advisor to express validation and be caring towards the student. Other participants wanted advisors that held more seemingly professional yet cordial relationships and firm boundaries. Participants highlighted that there could be numerous changes that could occur with advisors, including having to switch labs. They additionally discussed experiences with expressing emotion in front of advisors, and how that experience went, depending on the fit between the advisor and the participant.

The next theme that emerged was the Disclosure theme, which conveyed experiences of disclosing mental health experiences to others. The first subtheme was Disclosure from Faculty and Program. Participants reported on their desire for faculty to engage in more self-disclosure. It was discussed if faculty chose to self-disclosure versus choosing not to self-disclosure. Participants encouraged official public statements from well-known psychologists. Participants discussed messages about disclosure that they received from faculty that was supportive and not supportive.

In the Student Disclosure Experiences subtheme, participants differed in their experiences with disclosure. Participants varied in their decisions to choose and not chose to disclose mental health experiences to others, including peers, and faculty. They shared

interpersonal experiences with disclosure. Participants discussed how they purposefully framed symptoms in a way to reduce risk. They also self-disclosed as a therapist to their clients.

Participants described various beliefs about disclosures within the subtheme Beliefs of Disclosures. They reported on their thought process of it was good or bad to self-disclosure. Participants discussed difficulty navigating power dynamics when it came to deciding to self-disclose. They noted cultural differences and obstacles that arose with disclosures. Participants described their experience disclosing physical health concerns versus mental health concerns. They shared why students chose to not self-disclosure, due to beliefs that no one else was self-disclosing, that they weren't comfortable with it and that they feared negative consequences for doing so. Participants held the belief that disclosure led to problems and that there was stigma associated with self-disclosure.

The next theme was Unique Relationships with Psychotherapy which shared participants' experiences regarding psychotherapy. The first subtheme was Personally Receiving Psychology Treatment. Here participants shared their current and historical experiences of treatment, which included positive and negative experiences of psychotherapy and medication experiences. Participants also identified obstacles to treatment, which included weekly therapy not being attainable and high cost of services. They shared messages about receiving psychological services. Participants described benefits of treatment for handling graduate school. Lastly, they reflected on applications of their own experiences in treatment to their practice being in the role of the therapist.

Participants shared their experiences of learning to practice psychotherapy and assessment in the subtheme Providing Treatment as a Therapist. They discussed aspects they liked about being a therapist, although they acknowledged how it was a surprisingly challenging

process. Participants remained reflective of their own therapy experiences. They reported that providing treatment while having a history of diagnoses or treatment could offer something unique in the role of a therapist. They emphasized empathy, insight and a strengthened therapeutic alliance as being positive benefits for providing treatment as a person who has their own treatment history.

In the Wounded Healer subtheme, participants responded to the description of a wounded healer. They provided reactions to the concept, with some participants relating to the idea of a wounded healer and other participants not relating to it. Some participants expressed concerns over the scientific nature of the concept. Participants pondered the benefits of a wounded healer. It was determined by participants that wounded healer concept was not necessary, but that its components could have benefits as a therapist. It would be important to consider the potential benefits of providing treatment from students who have already been in treatment beforehand.

In the last theme, Resiliency, participants reviewed what motivated them to continue to finish graduate school even when facing unique stressors in an already stressful environment. Participants offered specific advice under the subtheme Coping Strategies. Here, participants determined that self-care was useful, but could not be herald as a "fix all." They identified various motivations, including interpersonal, financial, and intrinsic motivators. Some participants utilized an optimistic approach when it came to thinking about the future. They prioritized their relationships and engaged in socialization with others. Participants engaged in meaningful and fun activities. They made a point to be gentle with themselves. Participants used humor. They reported they just "powered through" difficulties. Participants stressed the importance of work-life balance, enacting boundaries, and effectively managing their workload. They utilized clinical knowledge and engaged in therapeutic techniques themselves.

Lastly, participants offered advice to other students in the similarly named subtheme Advice for Other students. Participants stressed it was important for students to remember their values. They should know how to advocate for themselves before attending graduate school. Participants encouraged others to set up good social support systems, which included utilizing cohorts. Some participants reported that it would likely be the students that needed to take the first step to obtain support from their program. Participants recommended that students find a therapist to help manage stressors. They encouraged others to set boundaries and engage in fun activities. Participants offered comforting statements to other students.

Recommendations for Programs

This study's findings offer many recommendations for programs to support students with recent and historical experiences with personal mental health. Firstly, there should be a greater cultural shift in self-disclosure. Programs should provide a space for students where they feel that they will be encouraged and supported to engage in self-disclosure. One way to do this would be to encourage faculty, particularly advisors, to self-disclose their struggles with personal mental health experiences. This takes great courage and vulnerability but is still highly recommended. Doing such actions could cause a shift in dynamics in the program and leave an opportunity to foster stronger bonds between mentor and mentees. This also works to eliminate a culture of silence and worries of stigma that could occur.

Programs, faculty, and advisors should think long and hard about how they are offering feedback to students with current and historical mental health experiences, particularly when it comes to APA's self-care component. It is not out of the ordinary that such a stressful environment of graduate school could foster the perfect storm for a psychological episode, be it depressive or otherwise. With all the self-care in the world, it still might not be possible for

students in this population to function without impairment. In that case, receiving poor scores in self-care on student evaluations is likely to be hurtful to students and may inhibit them from further self-disclosure.

Students' loyalties to their programs should not be "tested," nor should they have to "prove themselves" that they are dedicated to their program. There were numerous stories shared by participants where their program put extra pressure on them to do just that after they self-disclosed mental health struggles and faced impairment in their studies. How these students managed to stay in their program with extra stress given to them by their advisors, faculty, and program should be admired and further studied, as all odds point towards such unsupportive behaviors from their program leading students to drop out.

Programs and faculty are encouraged to seriously consider how they can change to support this population better. They should be aware that students may not know what accommodations could be afforded, so they may not have an answer when asked how they can best be supported. Take some time to think outside the box on how students could be uniquely supported within your program. It would also be good to discuss with the university's disability services center. Faculty should be updated on the rights of students with disabilities and how the system works for students to be able to access and achieve those accommodations. Yes, even at the graduate level, students with disabilities are deserving of accommodations. No, this does not hamper their learning or put them off from being able to handle "the real world." The real world tries to accommodate individuals with disabilities. There is no reason to make graduate school harder than it already is for this population.

The American Psychological Association is finally addressing the graduate student mental health crisis. With its development of the American Psychological Association &

APAGS-BEA Work Group in 2018, APA released suggestions and declarations for change in 2023 that each doctoral psychology program must address. It is suggested that programs take such changes as an opportunity for growth and a way to unravel the toxic harm that has plagued academia. Graduate school should not be so hard emotionally, which does not mean the students experience less rigor in their courses. Instead, this can be a time to reimagine the vision of academia. While doing just that, make sure to consider the students who come into graduate school with histories of their own mental health struggles.

Limitations

There were several limitations of this study. Initially, there was supposed to be at least one research assistant who would have helped with coding, creating themes, and cultivating inter-coder reliability. However, due to unforeseen circumstances and time restraints, research assistants could not be utilized for this study. To make up for this, the researcher made sure to include vast details and quotes within the findings to show a clear line of reasoning for the formation of themes and subthemes. The researcher additionally collaborated with the dissertation committee chair, who intently reviewed findings and offered feedback multiple times. The results were then brought to the researcher's dissertation committee for final review and followed their suggestions as well.

This study achieved saturation during the interviewing stage. This could raise issues with potential oversampling. Oversampling in qualitative research could lead to more difficulties with managing the dataset, due to the numerous amounts of codes and themes. Indeed, this study had over 2000 codes initially. What this meant for the researcher was a longer data analysis timeframe than first expected in order to manually sort through all the codes and group them into themes.

Suggestions for Future Research

For future research, it would be beneficial to examine this population through a qualitative disability lens. Such a study could provide information in a way that highlights the fact that students with psychological disorders do have a disability. This study could explicitly show the impact of managing disability through graduate school and what that means in a broader sociocultural context.

Future research could include a long-term study following clinical psychology graduate students from their first year of graduate school to their careers as clinical psychologists. It would be interesting to document the trajectory of their mental health and overall well-being and examine the resiliency that kept them continuing their career path.

Another potential future research idea would be to examine the similarities and differences among various graduate programs within different fields of psychology. Students who are from different domains of psychology, such as those with educational psychology backgrounds, would likely be able to relate to the lived experiences of clinical psychology graduate students while also holding unique lived experiences of their own.

Additionally, given that the field of academia appears to yield a high-stress environment and that psychologists continue to experience distress and severe symptomology, it would be interesting to examine the faculty's experience of academia. Lastly, faculty's perceptions of training graduate students and how it is similar and different graduate students voiced wants from a mentorship should be examined to understand better how to improve advisor and student satisfaction with mentorship experiences.

Reflection

I will finish this project by writing a first-person reflection, as it will best convey the aims and heart of this project.

I knew, logically, that completing a dissertation was already a hefty task. I had been doing hard work as a graduate student for years, so I did not suspect it to be much different than the struggles I already experienced. I ended up being right and wrong on some accounts. Indeed, the dissertation was a colossal project that stretched my capacity and well-being. It affected my mental health, which was already rocky at times.

Moreover, as data analysis kept getting delayed, it took more work to reenter the project. It felt like I was swimming in data with no exit. Nevertheless, I did what many of the students in this project did: I kept going. I am still not entirely sure how I did it, but perhaps that is a more common experience than I previously allowed myself to consider.

I knew I was not the only student with ongoing mental health struggles, but I still was not expecting the sudden surge of interest from people wanting to participate and share their stories. I only posted to one listserv, and within a week, I had gathered more than double the participants I proposed for the study. I opted to close the study at fourteen participants, as I knew this would likely provide ample data for saturation given the opportunity for three interviews per participant. I also struggled to turn down those who wanted to share their stories. I know how powerful it can be to share your story with someone who understands you. Ultimately, I had closed the screening survey to additional potential participants so this dissertation could be completed in a reasonable timeframe.

In a way, it makes me feel less alone in seeing that I am not the only one who has gone through such struggles. Again, I figured that to be the case due to what I have read with research

and people in the field of psychology who have gone public with their own stories of mental health. However, seeing it outside of my bubble and in the flesh made me feel so happy, yet also sad, for other people have experienced it. Still, it was a unique experience to realize that you are not alone in your circumstances and that others have experienced similar suffering but also resilience.

These are stories and experiences from just a few students and do not represent everyone. However, these stories will be relatable and eye-opening, as human suffering and resilience are easily recognizable themes. I hope this study comforts those who need it - you are not alone. You have rights. We can change things. Graduate school should not make you want to kill yourself, which was something I experienced myself, yet I also heard from numerous other students throughout this project.

Still, I wonder about the students like me and the students in this study who did not make it through their program. I think about the students who did not have second, third, or fourth chances like me. I know how much of a difference it made that I had the strong support of my current advisor and several faculty members to continue despite my trajectory in graduate school being far from the ideal experience. I am reminded of the Coping Strategies subtheme referencing the resiliency and actions that aided students staying in graduate school despite the stressful environment and hits to their mental health. It serves as a steppingstone for future research, but I do not think I uncovered the true ethos of the resiliency and passion of these students.

Furthermore, I believe there are positives to take away from hardship. Others and I should not have had to undergo hardship, but we did. Therefore, I think it can still be good practice to acknowledge the good that comes from this population’s history. I believe such

experiences of mental health journey will allow for greater empathy and understanding when it comes to working with clients or participants who have faced similar hardships. The wounded healer concept could allow for greater healing abilities, of which have not been sufficiently studied.

My wish for this study is to show faculty advisors and directors that there is a way to support individuals under their care and that we should consider how to do things differently, especially given how the suffering of so many students has come to light.

I feel for those who have gone deeper and shared their stories with me. Since starting these interviews, I have felt the urge to wish to be their friend and continue to contact or advocate for them on their behalf. I think I felt "pulled," but I do not think that means it is a horribly bad thing, and I am in the wrong for feeling this. I relate to these participants and sincerely desire to promote awareness and advocacy to help them and improve our field overall. It is not okay for students to spend so much of their lives and dedication for four-plus years and not have good support and resources from faculty/mentors/supervisors asking so much of them. It is a disservice and, frankly, inhumane to put students through such conditions.

Students have rights. Times have changed. Current faculty should not have had to go through what they did, either. It was not okay that they were treated the way that they were. We need to stop the cycle of abuse and hurting students on a personal level. If these things happened at a 9-5 corporate job, we would tell people to be assertive - and demand change. Know your worth. Go somewhere else that is deserving of you and your time.

However, where do people go when there seem to be structural concerns in the training of psychologists? There would be significant benefits in changing the structure of clinical psychology graduate school expectations and programs. The American Psychological

Association has already taken steps to examine the well-being of graduate students in psychology and values that programs should consider when allocating resources and expectations (American Psychological Association & APAGS-BEA Work Group, 2023).

I am reminded of the Messages of Disclosure from Faculty and Program subtheme under the Disclosure theme, which gave me a strong emotional reaction as I heard about students' experiences within this domain. Students had heard that graduate school was not considered the time nor place for self-disclosures and to avoid personal issues. Such moments strongly complement the last theme of Separation of Identity. Students are not allowed to exist as their whole selves within a space that values self-reflection and is training students to provide psychological treatment to others. If we cannot be our authentic selves as therapists, then we cannot be fully present with our clients or those overseeing our training. It may be a far-off dream but imagine how wonderful it would be for students to be able to share their mental health struggles within graduate school, not to feel as though they are hiding or some failure for feeling the way that they do. Furthermore, that could trigger a change in learning how to foster strengths and resiliency in such a way that protects and extends the careers of psychologists, which could combat burnout and a continuation of feeling as though there is nowhere to turn to for help.

I am aware these are all grand statements and yet, I encourage readers to imagine such a supportive future and then take a step to make a slight difference in your own life, whether to support yourself or others.

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Appendix A

IRB Informed Consent Form

UNIVERSITY OF SOUTH DAKOTA
Institutional Review Board
Informed Consent Statement

Title of Project:	Exploration of the lived experiences of graduate students with histories of mental health diagnoses navigating clinical psychology doctoral programs
Principal Investigator:	Beth Boyd, 105 Noteboom Hall, USD, Vermillion, SD 57069 Beth.Boyd@usd.edu (605) 658-3710
Other Investigators:	Hannah Flanery, University of South Dakota, Vermillion, SD 57069 Hannah.Flanery@usd.edu (605) 658-3710

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be currently enrolled in a clinical psychology Ph.D. program within the United States, completed at least two years of said program, have a history of being diagnosed with a psychological disorder, and be experiencing recent psychological distress. Taking part in this research project is voluntary. Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the study about and why are we doing it?

This study aims to examine current clinical psychology graduate students' experiences with personal mental health concerns. About twenty people will take part in this research. Findings will be used to emphasize participants' stories and make recommendations to promote support and awareness within the clinical psychology field.

What will happen if you take part in this study?

If you agree to take part in this study, you will be asked to participate in two individual interviews on an online platform. These interviews will be audiovisual recorded. You will be asked about your personal mental health experiences and your experiences within graduate school. The initial interview and follow up interview will each take 1-2 hours and more as

needed, depending on how much you would like to share. An optional, final meeting will be offered to discuss results of the study, if desired be the participant. Published findings from this study will include direct quotes provided by you under the name of a pseudonym you choose.

What risks might result from being in this study?

There are some risks you might experience from being in this study. Possible risks could include feelings of discomfort when discussing personal mental health experiences or concerns regarding anonymity. Participants are encouraged to contact the National Suicide Prevention Lifeline by calling (800) 273-8255 or the Crisis Text Line by texting HOME to 741741.

The study will not disclose your real name or graduate school affiliation. You will choose your own pseudonym. You will have a chance to review your individual interview transcriptions as well as the final study findings, which will allow you to bring up potential identification concerns before the future publication of results.

How could you benefit from this study?

Although you will not directly benefit from being in this study, others might benefit from your participation. You will be helping to increase the awareness of clinical psychology Ph.D. students' experiences. You will be contributing to future interventions to aid this population.

How will we protect your information?

Given the small field of psychologists, there is a risk that participants could be identifiable. To make this more unlikely, you will be asked to choose a pseudonym that will be used for your interview transcriptions and references to you as a participant. Participants' actual names, contact information, and pseudonyms will be kept on an encrypted flash drive that will be stored in a locked drawer in the researcher's office.

Interview audiovisual recordings will be stored on a secured online platform. Upon completion of the interview transcriptions, the interview audiovisual recordings will be deleted. You will be able to review the transcriptions of your interview(s). You will be able to request edits and/or redactions within your transcriptions to protect your anonymity. Copies of the interview transcriptions and researchers' notes will be kept on a secured online platform and in a locked file cabinet in the researcher's office.

How will we compensate you for being part of the study?

Participants will be compensated $50 in prepaid electronic credit card for completion of the initial interview. An additional $50 prepaid electronic credit card will be given for completion of the follow-up interview. There will be no financial compensation for the optional final meeting.

Your Participation in this Study is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

Contact Information for the Study Team and Questions about the Research

The researchers conducting this study are Hannah Flanery, M.A. and Beth Boyd, Ph.D. If you have questions, concerns, or complaints about the research please contact Hannah Flanery at Hannah.Flanery@usd.edu or Beth Boyd at Beth.Boyd@usd.edu or 605-658-3710 during the day.

If you have questions regarding your rights as a research subject, you may contact The University of South Dakota- Office of Human Subjects Protection at (605) 658-3743. You may also call this number with problems, complaints, or concerns about the research. Please call this number if you cannot reach research staff, or you wish to talk with someone who is an informed individual who is independent of the research team.

Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. Keep this copy of this document for your records. If you have any questions about the study later, you can contact the study team using the information provided above.

Appendix B

Screening Questions

1. Are you currently enrolled in a clinical psychology Ph.D. program within the United States?
    a. Yes
    b. No
2. What year are you in your graduate program?
    a. 1st year
    b. 2nd year
    c. 3rd year
    d. 4th year
    e. 5th year
    f. 6th year +
3. Before entering your current graduate program, were you ever diagnosed with a mood disorder and/or personality disorder by a medical or menta health professional?
    a. Yes
    b. No
4. Do you have a current diagnosis of a mood and/or personality disorder diagnosed by a medical or mental health professional?
    a. Yes
    b. No
5. Have you been recently distressed or concerned about your mental health?
    a. Yes

b. No

6. Would you be interested in being contacted later to be interviewed?

    a. Yes

    b. No

7. Please provide an email address to contact you

    a.

Appendix C

IRB National Crisis Hotline Resources Form

National Crisis Hotline Resources Form

National Suicide Prevention Lifeline

Call: (800) 273-8255

https://suicidepreventionlifeline.org/

Taken from website: The National Suicide Prevention Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week.

Crisis Text Line

Text: HOME to 741741

Message on Facebook

https://www.crisistextline.org/

Taken from website: Text HOME to 741741 from anywhere in the United States, anytime. Crisis Text Line is here for any crisis. A live, trained Crisis Counselor receives the text and responds, all from our secure online platform. The volunteer Crisis Counselor will help you move from a hot moment to a cool moment.

Appendix D

Protocol of Interview Recruiting to Storage of Data

1) Recruitment email with link to a Qualtrics screening survey was sent to Google group "Psych Grad Student Research Participation Requests."
2) Participants' eligibility was determined by the screening survey responses. Eligible participants provided an email for contact information.
3) The researcher sent an email with IRB approved document, national hotline references, and asking to schedule an initial interview via Zoom.
4) The initial interview is conducted and recorded via Zoom.
5) The initial interview recording is then uploaded to Box.com and deleted from the computer.
6) The initial interview recording is then uploaded to https://www.happyscribe.com for transcription from Box.com.
7) A copy of the initial interview transcription is uploaded to Box.
8) The initial interview transcription is deleted from https://www.happyscribe.com.
9) The video audio recording of the initial interview is deleted from Box and https://www.happyscribe.com.
10) The researcher confirms the email address of where to send the initial interview transcript.
11) After confirmation, researcher sends copy of the initial interview transcript for participant to review.
12) The second interview is conducted and recorded via Zoom.

13) The second interview recording is then uploaded to Box.com and deleted from the computer.
14) The second interview recording is then uploaded to https://www.happyscribe.com for transcription from Box.com.
15) A copy of the second interview transcription is uploaded to Box.
16) The second interview transcription is deleted from https://www.happyscribe.com.
17) The video audio recording is deleted from Box and https://www.happyscribe.com.
18) Researcher sends copy of interview transcript to participant for review.

Appendix E

Interview Protocol

Pre-Interview Protocol

1) Ask to start recording.
    a. If okay, start recording.
    b. If not okayed, end the interview.
2) Introduce study goals, expected project timeline, and participant participation expectations.
    a. Receive verbal consent to continue.
3) Review and confirm participant criteria.
4) Assess participant's current level of distress.

First Interview Questions

Introductory Questions

1) How would you describe yourself as a person? Such as your identities, what or who you value, things like that.
2) What was your mental health experiences and journey like before starting your current graduate program?
3) What made you interested in this career?

Mental Health Journey in Graduate School

4) How would you describe your mental health journey and personal experiences with your mental health in graduate school so far?
    a. What have you found to be the most difficult? The most surprising?

5) On an individual level, how have you managed/coped with pressures from being in graduate school?
6) What support (if any) have you received from your advisor, peers/cohort, program faculty, program leadership, and university disability services?
7) What advice would you give other people who have also had a history of mental health concerns prior to graduate school?

Wounded Healer Identity / Clinical Trainee Identity

8) Have you heard of the concept of a wounded healer?
    a. Read definition: The wounded healer is an archetype that describes a provider who has participated in the healing process of their mental health struggles and, as such, can utilize the essence of their own healing experiences to provide more effective healing to others who are experiencing mental health concerns.
    b. What is your reaction to hearing that? Agree/disagree? Emotional reaction/ thoughts?
9) What does it mean to be a student clinician providing mental health services to others while simultaneously having your own mental health diagnosis history and experiencing current mental health concerns?
10) What is advantageous and/or disadvantageous about having your own mental health history and providing treatment for others?
11) How might your own mental health history and current exacerbated symptoms guide your clinical practice as you provide treatment for others?

COVID Impact

12) How has the emergence of COVID impacted you (regarding being a clinical psychology graduate student with history of mental health diagnosis and current mental health concerns) and the potential support and hardships you have experienced thus far?
    a. How has this disaster allowed for greater understanding (of others around you) towards mental health disabilities (OR has it been 'business as usual,' OR have there been greater expectations)?

Further Reflection

13) If you could say something to your past self who has yet to enter the program, what would you say?
14) Let's say a friend who has experienced a similar mental health journey as you, is interested in applying to clinical psychology graduate school. What would you say to them? Advice? Encouragement?

Second Interview Questions

1) What was it like reading transcript from the first interview? Similarities/differences to now? Thoughts? Reactions?
2) Any major events occur since last meeting (for first interview)? Good/bad?
3) Thoughts on the idea of self-care and managing mental health in graduate school?
4) Anything you would change in your program?
5) What has been your experience with financial in/stability throughout graduate school?
6) Would you do anything differently as you look back on your journey so far?
7) What do you envision for your future as a psychologist?
8) What are your strengths?

Crisis Risk Protocol

9) The researcher electronically shared a pre-made document containing national crisis hotline resources.
10) At the beginning of the interview, participants' rate their current level of distress on a scale of one to ten. Answers of "one" indicate no levels of distress, while answers of "ten" indicate highly intense levels of distress.
    a. At answers "eight" or above, reschedule the interview to a different date.
11) If a participant becomes upset or triggered by talking about their experiences, pause the interview.
    a. Initiate effective emotional regulation by administering grounding techniques (i.e., deep breathing and imagery exercises).
    b. Re-assess the participant's current level of distress.
        i. Answer of eight or above, suggest ending the interview in order to engage self-care.
        ii. Offer option of rescheduling the interview.
        iii. If the participant desired to continue with the interview, take a five-minute break.
            1. Suggest the participant take a short walk, drink a glass of water, or talk about a non-relevant research topic.
        iv. After the break, reassess the participant's current level of distress.
            1. If answered eight or above, ended the current interview.
            2. Again, initiate the use of grounding techniques.
            3. Highlight list of resources provided for national crisis hotlines.

4. If the participant desires to continue with the study, reschedule the interview for a different date.

Appendix F

Word Cloud