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The Prevalence and Perceptions of Self-relevant Research ("Me-search") in Psychological Science

Andrew R. Devendorf
*University of South Florida*

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The Prevalence and Perceptions of Self-relevant Research ("Me-search") in Psychological Science

by

Andrew R. Devendorf

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy
Department of Psychology
College of Liberal Arts and Sciences
University of South Florida

Major Professor: Jonathan Rottenberg, Ph.D.
Peter Clayson, Ph.D.
Robert Dedrick, Ph.D.
Fallon Goodman, Ph.D.
Sarah Victor, Ph.D.
Joseph Vandello, Ph.D.

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DEDICATION

This dissertation is dedicated to all who dedicate their lives to reducing stigma toward mental health difficulties, such as by normalizing, validating, and supporting people who experience mental health challenges. Despite being highly prevalent, mental health difficulties remain misunderstood (intentionally or unintentionally) by too many people. Our society does not provide enough resources, incentives, or structural support for people devoted to providing clinical services, conducting research, or engaging in advocacy. As a result, too many people experience suffering that can otherwise be resolved. While awareness has increased over the last 20 years, there is still a long way to go. I hope that future conversations about mental health go beyond throwaway statements like, “Mental health is so important” and “break the stigma,” and instead facilitate shared understanding and knowledge about actionable ways to cultivate stabilization, resilience, and well-being.
ACKNOWLEDGMENTS

Earning my Ph.D. in clinical psychology was extremely challenging, but not for the reasons I anticipated, nor do I believe I could have understood these challenges unless I experienced them. The training model, reward system, and professional culture need to be updated and improved. The paradox of clinical psychology training is that many (most?) trainees will experience considerable emotional distress, uncertainty, and feelings of powerlessness throughout their long graduate tenure. Although structural issues are inherently difficult to address, I do not believe this pathway has to be this way. With that said, I need to acknowledge those who provided me with support and hope during this arduous path. First, I have unlimited appreciation for my girlfriend and life partner, Julia McDonald, who was the best part of pursuing this degree. Second, big thanks to my mentor, Dr. Jonathan Rottenberg, for supporting my development during this graduate tenure. Third, thank you to my parents, Pam and Robert Devendorf, for their love and support. Fourth, this dissertation would not exist without my research assistants, Thomas Campana and Samantha Salley, for helping extract thousands of email addresses for data collection. Similarly, thank you to Dr. Kim Rios for providing me with a great head-start on constructing an email database. Last, but not least, here are some other key people worthy of my appreciation (in no particular order): Dr. Jerry Doaty, Ben Listyg, Dr. Curtis Puryear, Dr. Vanessa Panaite, Dr. Chris Fowler, Dr. Sarah Victor, my dissertation committee, and everyone who supported my research on GoFundMe. Thank you!
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ABSTRACT

Self-relevant research (i.e., me-search; SRR) is research that is informed by lived experience or having close connections to a topic. The disclosure of SRR may impact how a researcher is viewed in professional contexts, like an application to graduate school, and thus can impact who is recruited and retained in psychology. Although SRR appears to be common in psychology, little systematic research exists on its prevalence by subfield of psychology or how SRR is perceived. This study examined SRR across psychology disciplines. An online survey was administered to faculty and graduate students (N = 1313) affiliated with accredited doctoral programs in psychology. Participants were asked if they had ever conducted SRR and responded to one of six manipulated vignettes that depicted a hypothetical researcher, their research topic (i.e., depression, cancer, or sexual orientation), and whether they conducted SRR (i.e., SRR vs. non-SRR). Results showed that most participants (57.4%) had conducted SRR, with a higher prevalence among participants in clinical psychology subfields (68.6%) than non-clinical subfields (52.0%). Across all participants, participants reported more stigmatizing attitudes about SRR on the topic of depression than on the topic of cancer or sexual orientation. SRR on cancer or sexual orientation was also associated with more positive attitudes than SRR on depression. Contrary to hypotheses, clinical and non-clinical fields did not show differential attitudes about SRR on depression. SRR is common within psychology, yet psychologists may hold varying attitudes about its pursuit and disclosure depending on the SRR topic. Future field-wide efforts should seek to create an open dialogue about how to navigate professional challenges related to perceptions of SRR, while simultaneously reducing SRR and mental health stigma.
CHAPTER 1: INTRODUCTION

Positionality Statement

Given the topic of this study, I believe this study warrants a positionality statement. I am someone who conducts research on depression, suicide, and mental health stigma. I have been drawn to studying these areas, in part, from my personal and familial connections to these topics (e.g., Devendorf, 2022). I thus identify as a self-relevant researcher, or someone who does “me-search.” Although many additional factors drive my motivation to study these topics, I believe these personal experiences have been valuable in enriching my research. It is possible that these experiences make me more receptive to self-relevant research. However, rather than conceal this background, I believe it is scientifically useful to practice transparency of these perspectives.

Overview

Self-relevant research (SRR) is the pursuit of research by those who have a lived experience with, or close connection to, their research area (Devendorf, 2022). SRR has been referred to as “me-search”, but this term may carry pejorative connotations. For example, the “me” in “me-search” may connote that a researcher is selfish or is looking to push a personal agenda, rather than pursue science “objectively” (Amabile & Hall, 2021; Gardner et al., 2017).

Historically, it has been uncommon for psychologists to publicly disclose that they conduct “self-relevant research,” perhaps due to fears over the negative potential repercussions of disclosure (Carey, 2011a; Carey, 2011b; Linehan, 2021; Victor et al., 2021). For example, in clinical psychology, a researcher who studies depression and has a history of depression may face prejudice and discrimination related to their mental illness (Devendorf, 2020; Victor et al.,
This prejudice may extend to other visible and invisible researcher identities, such as those with physical disabilities (Andrews & Lund, 2015; Bogart, 2024) and lesbian and gay sexual orientations (Altenmüller et al., 2021; Hu, 2016). In an initial investigation, we found that self-relevant researchers (i.e., “SRRers”) who studied mental health topics (i.e., depression, schizophrenia, suicide) were more likely to be viewed as biased, selfish, and less credible than non-SRRers (Devendorf et al., 2023). Two concerns are that such stigmatizing attitudes could harm professionals in psychology (Byrne et al., 2021; Harris et al., 2020) and conflict with psychology’s mission to de-stigmatize mental illness (APA, 2011).

Two key questions raised by these initial findings concern the breadth of the stigma toward SRR. Is SRR stigma broadly held or specific to the topic of mental illness? And is this stigma specific to the population of professionals in clinical psychology? To extend knowledge on this topic, this study investigated a wider sample of psychologists’ attitudes toward SRR, separately testing research topics: mental health (i.e., a researcher with or without depression), physical health (i.e., a researcher with or without cancer), and sexual orientation (i.e., a researcher who does or does not identify as a gay person).

**What is Self-relevant Research (SRR)?**

SRR is the pursuit of research by those who have a lived experience with, or close connection to, their research area (Devendorf, 2022). SRR is an identity-related construct that is determined by the researcher. Conceivably then, a researcher could have a lived experience with, or close connection to, their research area and not identify with SRR. Whether a researcher subscribes to the definition of SRR depends on the salience and meaning assigned to their personal experience. Most likely, a research topic that is important and strongly related to a researcher’s identity will determine if the researcher identifies as a SRR (Amabile & Hall, 2021).
Examples of SRR may include an anxiety disorder researcher who has been diagnosed with anxiety, or an alcohol researcher whose parents struggled with addiction. SRR also applies to many other identity-related experiences (e.g., religion; Rios & Roth, 2020). Examples may include a researcher with a physical disability who studies and advocates for other people with their condition (e.g., Bogart, 2024), or a person of color who studies discrimination and prejudice toward racial and ethnic minorities (e.g., Harris, 2021), or a researcher who studies LGBTQ-related advocacy who has a sibling who identifies as LGBTQ e.g., Hu, 2016; Sumerau, 2016).

**Why is SRR Important?**

SRR in psychology has historically been seen in a negative light. Some contexts for SRR include discussions of red flags in professional settings, like labeling disclosure of SRR as a “kiss of death” in the graduate admissions process, or conversations that include gossip about colleagues at psychology conferences (Devendorf, 2020). Many researchers are familiar with the phrase, “research is me-search,” which has been anecdotally observed in playful, comical, and sometimes judgmental contexts (Amabile & Hall, 2021; Devendorf, 2020; Gardner et al., 2017; Sumerau, 2016). Although the phrase might not be intended to harm, phrases like this may imply the existence of negative stereotypes about SRR, which may professionally disadvantage SRRers.

In clinical psychology, signs of stigma toward SRR are evident before someone even enters the field. Several renowned professional guides warn prospective applicants that disclosing a personal connection to mental illness may disqualify them from receiving an interview invite (see review, Devendorf, 2022). For example, prior to 2023, a popular advice guide by Dr. Mitch Prinstein, “Mitch’s Uncensored Advice for Applying to Graduate School in Clinical Psychology,” outlined three general reasons why students tend to be rejected from
programs (Prinstein, 2022). One reason stated (note: the guide has since been updated): “The application contains information that is widely inappropriate and unprofessional. Applicants who disclose their own psychopathology, for example, are often ‘screened out’ at this stage” (p. 26). This strong message suggests that SRR stigma, at least as it relates to mental illness, is endorsed by a sizeable portion of faculty. Indeed, one study of faculty members from 457 psychology graduate programs found that an applicant’s personal research connections may be viewed as a “kiss of death” in the admissions process to justify why applicants are rejected (Appleby & Appleby, 2006). A more recent review suggests that these negative attitudes persist today: disclosure of mental illness during the admission process on graduate applications may diminish one’s chances of getting admitted – even for strong applicants – across mental health professions (Salzer, 2021). On social media, academics have shared stories about applicants being rejected from grants after disclosing how their lived mental health experience connects with their research interest (e.g., Rutherford, 2023).

Similar risks of discrimination may exist for faculty who disclose SRR. For example, Elyn Saks, a prominent SRRer with lived experience of schizophrenia, received many cautions before disclosing her personal experiences in her memoir, “The Center Cannot Hold: My Journey Through Madness:”

“Dr. Saks surveyed friends and colleagues for years before publishing [her book] and got very mixed advice...Academic colleagues warned her that coming out with a disorder as serious as schizophrenia could only harm her. “You want to be known as the schizophrenic with a job?” one said” (Carey, 2011a, para 7).

By studying SRR systematically, psychology will be better positioned to understand the potential advantages or disadvantages faced by SRRers.
Conceptualizing SRR Through a Stigma Framework

How psychologists respond to SRR identities can be understood through a stigma framework (Link & Phelan, 2001; Link & Phelan, 2013). Stigma comprises reactions toward a social group, usually due to a specific characteristic of that group (Link & Phelan, 2001). While most human characteristics are ignored (e.g., in Western society, a person’s eye color is usually not considered an important grouping variable) some traits, either visible (e.g., race) or invisible (e.g., mental illness), elicit strong reactions from people with or without those traits. These traits are usually oversimplified or overgeneralized to facilitate demarcation of group identities. When groups are identified, they are then associated with labels, which can facilitate “us” versus “them” thinking (Estroff, 1989; Morone, 1997).

A rich social psychological literature has identified cognitive, emotional, and behavioral aspects that help organize the process of stigma: stereotypes, prejudice, and discrimination (see review, Rüsch et al., 2005; Stangor, 2016). Stereotypes, prejudice, and discrimination may be publicly perpetuated (i.e., public stigma), but can also be privately adopted by a person with a stigmatized identity (i.e., self-stigma). These two types of stigma—public stigma and self-stigma—can worsen one another. In the case of mental illness, public stigma is common and many members of the public hold and perpetuate stereotypes that people with mental illness are dangerous (Pescosolido et al., 2019). These stereotypes may contribute to prejudice in the form of cognitive and emotional reactions (Stangor, 2016). Cognitive reactions might include negative thoughts about people with mental illness (e.g., “People with mental illness are scary.”); emotional reactions might include fear and anger toward people with mental illness. These reactions can then result in behavioral discrimination, such as rejection or mistreatment of
someone with mental illness (Corrigan et al., 2005; Mejia-Lancheros et al., 2021; Russinova et al., 2011).

Public stigma may also lead to self-stigma. Self-stigma refers to what members of a stigmatized group may do to themselves if they internalize public stigma (Corrigan & Fong, 2014). For example, a person with mental illness might adopt the stereotype that they are dangerous. This stereotype adoption might contribute to negative thoughts (e.g., “I have mental illness and I’m dangerous. I’m a bad person.”) and emotions (e.g., fear of self, shame, guilt) from within oneself. This self-stigma might lead to maladaptive behaviors like not seeking help for one’s mental illness (for review see Clemente et al., 2015).

Among psychological scientists, stigma toward SRR may depend on the precise nature of the stereotypes about SRR and the specific research topic involved (Altenmüller et al., 2021; Devendorf et al., 2023). One reason why SRR in psychology has been historically problematic is that psychological science training has traditionally emphasized objectivity as a means to obtaining reliable and valid research (Levitt et al., 2022; Starbuck, 2006). The pursuit of objectivity is described as maintaining an impartial, unbiased, and neutral perspective, in which a researcher prioritizes empirical data over personal experience (Levitt et al., 2022). As such, psychological scientists may hold the stereotype that persons who engage in SRR lack or do not value objectivity (Levitt et al., 2020), and may even advise researchers against pursuing personally relevant research (Rudestam & Newton, 2014). Another way objectivity of SRR may be questioned is the presumption that a SRRer is trying to “push an agenda” to confirm their prior experiences with their social aims (Savolainen et al., 2023). As a telling example, a popular research methods book states the following while referring to SRR with the term “backyard research:”
“Backyard research [. . .] often leads to compromises in the researcher’s ability to disclose information and raises difficult power issues. The problems of reporting data that are biased, incomplete, or compromised are legend” (Creswell & Creswell, 2017, p. 184). Conceivably, colleagues who adopt the stereotype that SRR lacks objectivity would hold negative evaluations of the SRRer (e.g., “I don’t trust me-search because it’s not objective.”), which could result in negative emotions toward the SRRer (e.g., frustration, anger), and possibly behavioral discrimination (e.g., not hiring someone due to questioning their perceived scientific rigor). Additionally, whether SRR is judged negatively might depend on whether the SRR research topic is already a stigmatized identity. A SRRer who studies schizophrenia, for example, might face negative stereotypes associated with SRR and schizophrenia (e.g., stereotypes that people with schizophrenia are not mentally fit).

Ultimately, through documenting stereotypes associated with SRR, and associated research topics, psychologists can better understand why negative attitudes exist toward SRR, and why stigma may vary depending on a researcher’s SRR topic.

**What Stereotypes do Psychologists Hold About SRR?**

Despite the potential consequences of SRR stigma, there is limited data about psychologists’ perceptions of SRR across research topics. Most conclusions about of SRR are drawn from weak sources of evidence such as commentaries (e.g., Amabile & Hall, 2021; Gardner et al., 2017), advice guides (e.g., Devendorf, 2020; Rudestam & Newton, 2014), and survey research (e.g., Appleby & Appleby, 2006). According to these sources, SRR is associated with negative stereotypes, such that researchers who engage in SRR are biased, selfish, and lacking credibility.
Interestingly, psychology’s negative views of SRR may be lessening. Recent discussions by social scientists have challenged these negative stereotypes and supported a more favorable view of SRR (Amabile & Hall, 2021; Boyd et al., 2016; Devendorf, 2022; Harris, 2019; Lewis, 2017; Victor et al., 2022a). For example, these perspectives consider the value afforded by lived experience to understand complex phenomena, identity-related issues, systemic discrimination, and having the ability to connect with the studied research population. Amabile and Hall (2021) articulated the benefits of SRR:

“Personal experience may actually be essential for truly valid research – for accurately uncovering and deeply understanding the full range of complexities of certain phenomena, especially unexplored phenomena that involve unusual experiences, high degrees of emotionality, or identity issues” (p. 6).

In a related sphere, psychology programs across the United States are adopting efforts to increase the diversity, equity, and inclusion of historically marginalized groups (APA, 2023), which implies a recognition of the value and growing acceptance of researchers with lived experience. Recent commentaries, for instance, have called for academic institutions to develop initiatives to support and value lived experience among academic researchers with mental illness (Hawke et al., 2022; Jones et al., 2021). These commentaries reflect that lived experience can be a seen as a strength, as an SRRer may have more insight into an understudied topic, have more intrinsic motivation, and serve as a positive role model for the academic community.

The most direct evidence about SRR in psychology comes from a recent experimental study that examined SRR attitudes from a large sample of faculty, graduate students, and others affiliated with clinical psychology doctoral programs. In this study, Devendorf et al. (2023) presented participants with experimentally manipulated vignettes that depicted a hypothetical
researcher who conducted either SRR or non-SRR. Participants then rated the extent they believed the hypothetical researcher fit negative (e.g., the researcher has bad judgment, is biased, selfish, irresponsible, and should pursue a different topic) and positive stereotypes (e.g., the researcher is admirable, has insight, motivation, should be accepted in the academic community, and is a positive role model). Findings showed that beliefs about SRR depended on whether the respondent had personally conducted SRR. Specifically, psychologists and trainees who had never conducted SRR attributed more negative stereotypes to hypothetical SRRers than to non-SRRers. Conversely, psychologists and trainees who had conducted SRR rated hypothetical SRRers with more positive stereotypes compared to hypothetical non-SRRers. Regardless of whether a participant identified as a SRRer, psychologists viewed disclosure of SRR across professional contexts (i.e., discussing the development of one’s research interests) as more inappropriate than a non-SRR disclosure. Moreover, attitudes about SRR also varied depending on the research topic, with clinical psychologists and trainees rating SRR on mental illness topics (i.e., suicide, depression, and schizophrenia) more negatively than SRR on physical illness topics (i.e., cancer).

Overall, preliminary evidence suggests that clinical psychologists have mixed attitudes about SRR, which depends on the research topic and whether the respondent has a history of conducting SRR. SRR may be viewed with negative stereotypes (e.g., an SRRer is biased, irresponsible, or pushing an agenda), but it also may be viewed with more positive stereotypes (e.g., an SRRer is admirable, motivated, has more insight). It remains unclear, however, whether observed stigma toward SRR on mental illness is specific to clinical psychologists or generalizes across other subfields of psychology. It is also unclear if stigma toward SRR is unique to SRR on mental illness topics, or if stigma also extends to SRR on other topics of research.
Why SRR Mental Illness Stigma Could Vary by Psychology Subfield

Psychological science is broadly concerned with the study of how people think, feel, and act. Subdisciplines of psychological science include, but are not limited to, behavioral neuroscience, clinical psychology, cognitive psychology, counseling psychology, developmental psychology, experimental psychology, industrial and organizational psychology, school psychology, and social psychology. In recent years, one unifying goal in the field of psychology has been to embrace efforts to increase diversity, equity, and inclusion of historically marginalized perspectives (e.g., racial and ethnic minorities) from within the field (APA, 2023; Brannon et al., 2018). This mission has resulted in concrete efforts like the inclusion of “diversity statements” on department and organizational websites (APA, 2023) and in applications for graduate school, faculty positions, and grants. While commonalities exist across subfields of psychology, each subfield has its own mission, values, theoretical orientations, methodologies, and population of interest. It is thus conceivable that psychology subfields vary in their attitudes toward SRR and mental illness.

For example, psychologists in clinical, counseling, and school psychology programs (i.e., “CL” fields) are trained to study, assess, and provide treatment for people with mental illness, and naturally have more knowledge and familiarity with mental illness than psychologists who work in other areas. This knowledge and familiarity may paradoxically increase clinical psychologists’ proclivities to endorsing negative stereotypes about mental illness relative to non-clinical psychologists (Corrigan et al., 2019). As mental health providers, clinical psychologists are prone to the “clinician’s illusion,” where they overestimate the severity of general mental health problems due to working with populations who present with more chronic and severe psychopathology (Cohen & Cohen, 1984). Surveys show that mental health providers, including
clinical psychologists, are likely to believe that people with schizophrenia and borderline personality disorder are categorically different than non-disordered people who are unlikely to recover, which may promote “us” and “them” thinking (Dell et al., 2021; Kingdon et al., 2005; Magliano et al., 2004; Nordt et al., 2006). Preliminary qualitative research finds that negative attitudes toward mental illness may stem from burnout among mental health providers (Vayshenker et al., 2018). Further evidence of stigma from clinical psychologists comes when investigating the experiences of psychologists with depression. Survey and qualitative studies have shown that psychologists with depression feel isolated from their colleagues due to fears of negative judgment (Charlemagne-Odle et al., 2014; Gilroy et al., 2002; Hinshaw, 2008). Thus, one might predict that clinical, counseling, and school subfields hold more stigma toward SRR on mental illness compared to other subfields of psychology.

The Current Study

To understand SRR among psychological scientists, this study used an online survey to examine the prevalence of SRR and associated stigma in faculty and graduate students affiliated with United States doctoral programs in psychology. Perceptions of SRR were examined using an experimental approach, in which participants were randomly assigned to one of six manipulated vignettes that depicted a hypothetical researcher, their research topic (i.e., depression, cancer, or sexual orientation), and whether they conduct SRR (i.e., SRR vs. non-SRR). The topics of the vignettes were chosen to index invisible identities related to mental illness, physical illness, and social identities (see Method). The overall aims (see below) of the vignettes were to examine how psychologists and trainees broadly viewed SRR compared to non-SRR; to investigate if different topics of SRR were perceived differently; and to explore any differences between CL areas and non-CL areas toward SRR on mental health topics. This
vignette approach has been used extensively in social psychological and sociology research (Schoenberg & Ravdal, 2000), as vignettes are an effective means of assessing stigmatizing attitudes without directly asking participants about socially undesirable beliefs (Corrigan et al., 2003; Link et al., 2004). Vignettes can also be flexibly manipulated to depict hypothetical researchers of varying characteristics. Four core aims and hypotheses guided this study.

**Aim 1: Compare the prevalence of SRR across psychology disciplines.** First, this study documented the prevalence of SRR and made comparisons across psychology disciplines.

**Hypothesis 1.** SRR was expected to be more prevalent in clinical, counseling, and school psychology (CL) disciplines than non-CL subfields (i.e., behavioral neuroscience, cognitive psychology, developmental psychology, experimental psychology, industrial and organizational psychology, and social psychology).

A previous study ($N = 1,776$) estimated that the majority (55%) of professionals affiliated with CL programs have conducted SRR (Devendorf et al., 2023). This high estimate may be explained, in part, to the fact that clinical psychology disciplines is inherently focused on identity related topics like mental illness. The findings may also reflect that mental illness is a common experience that influences identity and interest to pursue clinical research. Arguably, in non-clinical subfields (i.e., “non-CL” fields) of psychology—such as behavioral neuroscience, cognitive psychology, developmental psychology, experimental psychology, and industrial and organizational psychology—it is less likely for the researcher to have personal and identity-related experiences that are related to one’s research because the topics are likely less personal.

**Aim 2 (conceptual replication): Examine how psychologists and trainees perceive SRR compared to non-SRR across research topics.** Second, this study compared attitudes about SRR to non-SRR among psychologists and trainees using six experimentally presented
vignettes. Three vignettes described a hypothetical researcher who conducts SRR, and three vignettes depicted a hypothetical researcher who conducts non-personally relevant research. By investigating this aim, the current study can shed light on the robustness and reliability of the previous Devendorf et al. (2023) findings.

**Hypothesis 2.** Psychologists and trainees were expected to stigmatize SRR and its disclosure more than non-SRR across research topics, although it was hypothesized that SRR would be viewed with more strengths-based attitudes.

This hypothesis seeks to conceptually replicate the findings from the previous Devendorf et al. (2023) study, which found that clinical, counseling, and school psychologists and trainees held more negative attitudes toward a hypothetical SRRer compared to a hypothetical non-SRRer, and disclosure (i.e., talking about how someone became interested in their research topic) of SRR was viewed less favorably than disclosure of non-SRR. However, the hypothetical SRRer was also viewed with more strengths-based attitudes than the non-SRRer, including attributes of being admirable and serving as a good role model. The findings that SRR was viewed with mixed attitudes were consistent with historical concerns that SRR could be more “biased” and recent commentaries that advocate lived experience can be a “strength” in research.

**Aim 3: Determine if psychologists and trainees stigmatize SRR on mental illness more than other identity-related topics.** Primary analyses examined if psychologists and trainees held more stigmatizing views toward SRR on mental illness compared to other SRR topics. Accordingly, vignettes were designed to represent research on mental illness (e.g., depression), physical illness (e.g., cancer), and social identity (e.g., racial identity).

**Hypothesis 3.** Psychologists and trainees were expected to stigmatize SRR on mental illness more than SRR on other identity-related constructs. This hypothesis was rooted in
previous findings (Devendorf et al., 2023) that showed SRR on mental illness was more stigmatized than SRR on physical illness. Additionally, it was hypothesized that stigma toward SRR on mental illness will be greater when compared to stigma toward SRR on social identity topics, given that depression often manifests as prejudicial beliefs about people’s mental fitness. For example, large-scale studies show that members of the public commonly associate people with depression as being dangerous, being unpredictable, being difficult to talk to, and being unlikely to recover (Pescosolido et al., 2021; Wood et al. 2014) – traits that psychologists may view as a hinderance in academic research. Meanwhile, the identities of being a member of the LGB community, or having cancer, are not associated with these negative stereotypes that are relevant to research.

Aim 4: Examine if clinical, counseling, and school (CL) psychologists and trainees stigmatize SRR on mental illness more than non-CL psychologists and trainees. In extending previous findings (Devendorf et al., 2023), this study examined if CL subfields held greater stigma toward SRR on mental illness topics compared to non-CL subfields.

Hypothesis 4. CL psychologists and trainees were expected to stigmatize SRR on mental illness more than non-CL psychologists and trainees.

This hypothesis was based on theoretical and empirical research showing that greater familiarity and knowledge of a stigmatized population may increase public stigma toward a particular population. Given that CL subfields have greater awareness and experience in working with people with mental illness, CL psychologists and trainees may endorse more stigma toward SRR on mental illness relative to non-CL psychologists and trainees.
CHAPTER 2: METHOD

Transparency and Openness

The study hypotheses and methodology were pre-registered on the Open Science Framework (OSF): https://osf.io/25xrp. All supplemental material, including the study materials (e.g., recruitment materials, survey), was uploaded onto an OSF repository: https://osf.io/t398f/. This study received Institutional Review Board (IRB) approval through Texas Tech University (IRB2023-362) in the expedited category (for letter, see: https://osf.io/dpza9).

Study Methodology Overview

An online survey was administered to professor-level faculty and graduate student trainees who were affiliated with doctoral degree granting institutions in the United States. Psychology programs were identified via U.S. News Report, with the goal of obtaining a large, representative sample of U.S. psychologists and trainees. CL programs ($N = 231$) were identified via the report of “Best Clinical Psychology Programs” (U.S. News Report, 2020; https://www.usnews.com/best-graduate-schools/top-health-schools/clinical-psychology-rankings). Disciplines for other psychology programs ($N = 245$) were identified via the report of “Best Psychology Schools” (U.S. News Report, 2023; https://www.usnews.com/best-graduate-schools/top-humanities-schools/psychology-rankings), which includes subfields in behavioral neuroscience, cognitive psychology, developmental psychology, experimental psychology, industrial and organizational psychology, and social psychology. These lists generated combined 308 doctoral programs in psychology. Participants’ contact information (e.g., email addresses) were obtained through public university websites. After visiting web links for each program, a
trained research assistant followed a standardized protocol to extract publicly available email addresses from all graduate students and professor-level faculty affiliated (e.g., enrolled, employed) with doctoral programs. See supplement 1 for standardized protocol.

**Recruitment.** An initial recruitment email was sent to 16,669 extracted emails on May 8, 2023. From the initial list of emails ($N = 16,669$), 3.38% ($N = 564$) were ultimately excluded from the final recruitment tally for the following reasons: email bounced ($n = 270$), participant was determined to be ineligible based on doctoral program criteria ($n = 261$), participant was no longer affiliated with a program or moved to an ineligible program ($n = 27$), participant was learned to be deceased ($n = 5$), and email address was incorrectly listed on website ($n = 1$). All the bounced emails were investigated and determined to be ineligible for the following reasons: the email was incorrectly listed on the website ($n = 151$), the emails were determined to be outdated based on feedback from a professor ($n = 56$), the email was no longer listed on the department website ($n = 53$), the email was determined to not be from a relevant doctoral program ($n = 9$), and the email was no longer listed on the website ($n = 1$).

The corrected recruitment pool thus included 16,135 emails that comprised of the following professional statuses: graduate students ($n = 7,681$), professor-level faculty ($n = 8,165$), and directors or department chairs of psychology ($n = 289$). A reminder email was sent one week after the initial email to increase response rates (Van Mol, 2017). Emails were sent by Dr. Sarah Victor of Texas Tech University, who is a collaborator, mentor, and committee member on the present doctoral dissertation. In cases of a potential conflict of interest (e.g., emails sent to people in Dr. Victor’s current program), a faculty mentor without a conflict of interest contacted these recipients.
To reduce sampling bias, this study was described as focusing on “research and career interests,” with no mention of SRR or mental health difficulties. The survey remained open for one month. Participants were able to enter a drawing for one of several $30 Amazon gift cards. This lottery incentive system has been found to be a cost-effective strategy to increase web survey participation (Laguilles et al., 2011). Additionally, emails sent to faculty members requested that they forward the recruitment email to their students.

The decision to use this “forwarding” procedure was weighed in consideration with several methodological advantages and drawbacks. The first advantage is the potential to increase the final sample size, with anticipation for low response rates. Low response rates were anticipated because of resource limitations (i.e., lack of funding to pay participants), anticipated participant survey fatigue following the COVID-19 pandemic (De Koning et al., 2021; Krieger et al., 2023), and the time limitations of the population of interest (e.g., prevalent feelings of overwork and burnout are among academics; Forrester, 2021; SenthilKumar et al., 2023; Warlick et al., 2021). The second advantage of this “forwarding” procedure is that it addresses the fact that programs vary in whether they list publicly available email addresses for students. As a result, this procedure increased the likelihood that both faculty and graduate students at the same university could participate. Lastly, a third advantage is that this “forwarding” procedure parallels a previous investigation of mental health difficulties and SRR among faculty and graduate students in clinical, counseling, and school psychology (Devendorf et al., 2023; Victor et al., 2022b), and thus allows for a more natural comparison with this previously collected data.

The primary drawback of this procedure is that a true response could not be determined because it was unknown if, or how often, emails were forwarded to graduate students. As a result of this procedure, the official response rate and representativeness of the final sample is unknown.
Given the number of emails sent ($N = 16,135$) and the number of useable responses, an approximate, upper-bound estimate of the response rate was 8.23% (see Missing Data section for more detail).

**Survey Instrument**

Survey items were informed and adapted from a previous study examining SRR (Devendorf et al., 2023). The survey was distributed via Qualtrics and took 15-30 minutes on average to complete. The survey also included items related to participants’ mental health symptoms and experiences. Below, I describe measures relevant to the current study’s aims. See supplement 2 for the survey instrument.

**Demographic and Professional Information.** All participants were asked about their age, gender, race, sexual orientation, professional status, and psychology area. For psychology area, participants could select from 18 different psychology disciplines, which included an “other” option (participants could also select more than one option). Participants were also asked to select their “primary area.” CL area participants were defined as those who selected a primary area from clinical, counseling, school, or neuropsychology subfields. Non-CL area participants were those who selected their primary area from all other subfields. Please see supplement 2 for the complete items.

**SRR Vignettes.** Following completion of consent and demographics items, but prior to questions regarding SRR engagement and mental health experiences, participants were randomly assigned and presented with one of six vignettes. This between-subjects design was selected to reduce participant burden and avoid potential order effects. Thus, a 2 (SRR vs. non-SRR) x 3 (depression vs. cancer vs. sexual orientation identities) between-subjects design was used (see Table 1). Six total vignettes were used to balance concerns about obtaining adequate cells sizes.
### Table 1: Manipulated Vignettes by Lived Experience and Research Topic

<table>
<thead>
<tr>
<th>Research Topic</th>
<th>Mental Health</th>
<th>Physical Health</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Identity</td>
<td>Depression</td>
<td>Cancer</td>
<td>Gay</td>
</tr>
<tr>
<td><strong>Self-relevant research</strong></td>
<td>Sam conducts research on <strong>depression</strong>. Sam became interested in depression research after finding out they have major depressive disorder. Since then, Sam has continued to learn about the experience of depression and wanted to study it. As a researcher who lives with depression, Sam really thinks there needs to be more evidence-based knowledge about depression topics which people can implement in everyday life.</td>
<td>Sam conducts research on <strong>cancer</strong>. Sam became interested in cancer research after finding out they have cancer. Since then, Sam has continued to learn about the experience of cancer and wanted to study it. As a researcher who lives with cancer, Sam really thinks there needs to be more evidence-based knowledge about cancer topics which people can implement in everyday life.</td>
<td>Sam conducts research on <strong>sexual orientation</strong>. Sam became interested in sexual orientation research after finding out they were gay. Since then, Sam has continued to learn about the experience of being gay and wanted to study it. As a researcher who identifies as a gay person, Sam really thinks there needs to be more evidence-based knowledge about lesbian, gay, and bisexual (LGB) topics which people can implement in everyday life.</td>
</tr>
<tr>
<td><strong>Non-self-relevant research</strong></td>
<td>Sam conducts research on <strong>depression</strong>. Sam became interested in depression research after taking a Clinical Psychology Course. Since then, Sam has continued to learn about the experience of depression and wanted to study it. As a researcher who has not lived with depression, Sam really thinks there needs to be more evidence-based knowledge about depression topics which people can implement in everyday life.</td>
<td>Sam conducts research on <strong>cancer</strong>. Sam first became interested in cancer research after taking a Health Psychology Course. Since then, Sam has continued to learn about the experience of cancer and wanted to study it. As a researcher who has not lived with cancer, Sam really thinks there needs to be more evidence-based knowledge about cancer topics which people can implement in everyday life.</td>
<td>Sam conducts research on <strong>sexual orientation</strong>. Sam first became interested in sexual orientation research after taking a Human Sexuality Course. Since then, Sam has continued to learn about the experience of being gay and wanted to study it. As a researcher who does not identify as a gay person, Sam really thinks there needs to be more evidence-based knowledge about lesbian, gay, and bisexual (LGB) topics which people can implement in everyday life.</td>
</tr>
</tbody>
</table>
in each condition while collecting a rich set of data. The vignettes were adapted from a previous study on SRR (Devendorf et al., 2023), which were modeled after prior studies of mental illness stigma (Link et al., 2004; Wood et al., 2014). Each vignette described a researcher with a gender-neutral name (i.e., Sam) who conducts research on one of the following topics: mental illness (i.e., depression), physical illness (i.e., cancer), and social identities (i.e., sexual orientation). Each topic was counter-balanced to depict either a SRR or a non-SRRer. Depression was chosen to index mental illness identities because it is the most common mental health difficulty experienced by psychologists and trainees (Tay et al., 2018; Victor et al., 2022), and thus results are more likely to have external validity and relevance. Cancer was chosen to index physical illness because there is wide public awareness about the condition, including its associated impairment and challenges, thus making it a worthy physical illness to contrast with depression. Sexual orientation was chosen to index social identities because it is often an identity that is noted in psychology DEI discussions (APA, 2023) Additionally, although different, each of these topics could be seen as representing invisible identities, where disclosure may elicit negative reactions.

Each vignette explained why Sam was interested in pursuing their research. In the SRR conditions, Sam was depicted as a “researcher who lives with” their research topic. Table 1 provides the vignettes for each condition. In the non-SRR condition, Sam was described as a “researcher who has not lived” with their research topic. After each vignette, two items served as manipulation/attention checks. The first item asked, “What is Sam’s research area,” and the second item asked, “Why did Sam get interested in their research topic?” Participants had to pass both manipulation checks to be included in subsequent data analyses (see below).
**Stigma, Strengths, and Disclosure (SSD) Scale for SRR.** After reading a vignette, respondents were asked follow-up questions about Sam’s research pursuit on the SSD scale (see supplement 3). The initial SSD scale demonstrated good preliminary psychometric properties in a large sample of faculty and graduate students in doctoral programs for clinical, counseling, and school psychology, which included support for a three-factor solution: stigmatizing attitudes, strengths-based attitudes, and disclosure views (Devendorf et al., 2023). Additionally, prior to this dissertation, cognitive interviews \((N = 7)\) were conducted with psychology graduate students \((n = 5)\) and faculty \((n = 2)\) to further validate, refine, and improve the SSD scale. Of note, the two faculty members who were interviewed both identified as experts in scale development and measurement. Cognitive interviews followed a protocol recommended by Caspar et al. (1999) to investigate participants’ comprehension, retrieval, decision, and response process. Both “think aloud” and “verbal probing” techniques were used to investigate participants’ experiences while taking the survey (see supplement 4).

All participants reported good levels of comprehension while responding to the items and believed that the items represented the constructs they intended to measure (i.e., stigmatizing attitudes, strengths-based attitudes, and disclosure views). Some items were edited based on feedback from the interviews. For example, participants preferred the term “trustworthy” over “credible” to index perceptions of trustworthiness. The interviewees also reported that the items reflect relevant beliefs about SRR among academic psychologists, and they agreed that the contexts regarding disclosure were comprehensive. Two interviewees were not aware of a positionality statement, and thus a definition was added on the survey. All interview participants also agreed that the level of detail provided in the vignettes achieved their intended purposes.
Following the interviews, the final SSD scale resulted in 26-items intended to capture “stigmatizing attitudes,” “strengths-based attitudes,” and “disclosure views” in relation to Sam’s research pursuit (see Appendix A for items). The stigmatizing attitudes subscale included 8 items that describe Sam as “biased,” “selfish,” “irresponsible,” “has bad judgment,” “not trustworthy,” and the beliefs that “Sam is pushing an agenda with their research,” “Sam should pursue a different topic,” and “Sam is doing research for wrong reasons.” The strengths-based attitudes subscale included 8-items that describe Sam as being “admirable,” having “motivation,” having “insight,” being a “a good role model for the academic community,” “should be accepted” by the academic community, and the beliefs that Sam’s research pursuit is “meaningful,” “respectable,” and “gives them a unique perspective.” These items were rated on a 5-point Likert scale (i.e., agree strongly, agree, neither agree nor disagree, disagree, disagree strongly).

Lastly, the disclosure views subscale provided participants with different contexts and probed for the degree to which it would be appropriate for Sam to disclose their “personal interest in their research topic” in each context. Contexts included: “publicly, such as when writing an essay for a magazine, blog, or talking with a journalist,” “when giving a talk at a research conference,” “to anyone in the academic community,” “during a campus interview,” “in a personal statement,” “in a diversity statement,” “on social media,” “while teaching a class,” “to an academic mentor,” and “in a positionality statement.” Items were rated on a 5-point Likert scale (e.g., very appropriate to very inappropriate). See Appendix B for details on the SSD scale.

**SRR Status.** After the vignettes and attitudinal items, participants were asked about whether they have ever engaged in SRR. Participants were presented with the following definition, used in a previous study (Devendorf et al. 2023), along with examples of SRR:
“Self-relevant research ("me-search") is research by someone with a lived experience with, or a close connection to, their research area. A close connection could be, for example, a family member or a close friend who has lived experience with their research area.”

Participants could choose one of four options: “Yes, I currently conduct this type of research,” “Yes, not currently but in the past,” “No,” or “Prefer not to answer.” Participants who marked either “yes” response were considered SRRers and presented with follow-up questions like: the topic of their SRR, the extent to which their SRR connects to their identity (e.g., personal lived experience, connection to their topic through another person, other, or any combination of the above), and whether the participant’s SRR includes mental health difficulties or related topics. See Appendix B for SRR items.

**Stigma Measures to Assess Convergent Validity.** Two validated measures of mental illness stigma were administered to investigate if there was preliminary evidence of convergent validity with the SSD scales on mental illness topics (see supplement 5). First, an adapted Social Distance Scale was included to assess behavioral intentions to interact with someone with a mental illness (Link et al., 1987); the adapted version includes items that are more relevant to clinical psychologists’ attitudes about people with mental illness (Tay et al. 2018). The Social Distance Scale includes five items that are rated on a 4-point scale (i.e., strongly disagree, somewhat disagree, somewhat agree, strongly agree). Example items include, “I would not spend the evening socialising with someone who has a mental health problem,” and, “I would feel upset or disturbed if I had to work closely with someone who has a mental health problem.” Possible scores ranged from 5 to 20 with higher scores indicating greater desire to distance
oneself from persons with mental health difficulties. The Social Distance Scale demonstrated acceptable internal consistency in the current sample (Cronbach’s alpha = .81).

Second, the “Fear/Avoidance” subscale of The Prejudice towards People with Mental Illness (PPMI) scale was included (Kenny et al., 2018). This subscale includes 8-items with the goal of broadly assessing negative beliefs about mental illness. Example items include, “I would find it hard to talk to someone who has a mental illness,” and, “I am not scared of people with mental illness” (reverse coded). The supplement provides the complete measure. Items are rated on a 9-point scale (e.g., very strongly disagree to very strongly agree). In this study, the average of the PPMI items was computed, with higher scores indicating more mental illness stigma. The Fear/Avoidance PPMI scale demonstrated acceptable internal consistency in the current sample (Cronbach’s alpha = .85).

**Face Valid Items to Assess Convergent Validity.** Eleven face-valid items were administered to assess participants’ attitudes about SRR across each research topic: depression, cancer, and sexual orientations. Participants were asked, “How appropriate or inappropriate do you believe self-relevant research is in the following situations?” Following this prompt, participants responded on a 5-point scale (i.e., very inappropriate, inappropriate, neither appropriate nor inappropriate, appropriate, and very appropriate) to different situations that depicted an SRRer. Example items include, “A person who currently experiences depression doing research on depression,” “A person with a prior history of depression doing research on depression,” and “A person with a loved one who experiences depression doing research on depression.”

**Feelings Thermometer.** In attempt to assess attitudes about each identity that was depicted in the vignettes, a single-item Feelings Thermometer was administered for each identity
This measure is used extensively in social psychology research to assess and compare broad attitudes about specific groups (Liu & Wang, 2015; Regenwetter et al., 2019). More recently, the measure has been integrated into mental illness stigma research as a measure of convergent validity (Kenny et al., 2018). In the current study, participants were presented with a thermometer and then asked single-item questions about the following identity groups: people with depression, people with cancer, people who are lesbian, people who are gay, and people who are bisexual. Participants then indicated their level of favorability to people from each of these groups on a scale from 0 (unfavorable) to 100 (favorable). An example item includes, “How do you feel overall about people who are gay? Provide a number between 0 to 100 to indicate your overall evaluation about gay people.”

**Data Analysis**

**Data Cleaning.** Distribution of variables was evaluated with skewness, kurtosis, and visual inspection of histograms. Data was considered non-normal with absolute skew greater than or equal to two or absolute kurtosis greater than or equal to seven (West et al., 1995). Skewness and kurtosis were acceptable across all scales, including the SSD subscales: stigmatizing attitudes (skewness = 0.38, \( SE = 0.07 \), kurtosis = -0.35, \( SE = 0.14 \)), strengths-based attitudes (skewness = 0.11, \( SE = 0.07 \), kurtosis = -0.62, \( SE = 0.14 \)), and disclosure views (skewness = 0.02, \( SD = 0.07 \), kurtosis = -0.20, \( SD = 0.16 \)). Floor and ceiling effects were inspected for each item and were acceptable.

In total, 21 participants were removed for failing attention checks (\( N = 7 \)) or being multivariate outliers (\( N = 14 \)) on the SSD scale. Outliers were removed on items that asked for numeric responses: age, number of years since completion of terminal degree, number of years engaged in research, and number of years engaged in clinical practice. Participants who reported...
values that were implausible (e.g., age greater than 100) were excluded from analysis, as were individuals who reported values for the latter items that exceed their reported age (e.g., a reported age of 30 and a reported number of years in research of 40). Additionally, for tests comparing mean differences, multivariate outliers were tested on the SSD subscales (i.e., subscales for stigmatizing attitudes, strengths-based attitudes, disclosure views) with Mahalanobis Distance, with a cutoff of \( \chi^2 \, df = p; \, \alpha < .001 \), where \( p \) = number of independent variables (Cohen et al., 2013). Multivariate outliers were also assessed for the Feelings Thermometer scales. For analyses that included this scale, 77 additional participants were removed. See Table 7 for information about the mean, standard deviation, range, skewness, and kurtosis for these measures. The larger number of outliers on the Feelings Thermometer may suggest that participants were confused about how to respond to this scale, and thus results are interpreted with some caution.

**Missing Data.** Missing data patterns were examined. While 1,503 participants started the survey, 175 participants did not complete any items following the demographics questions at the start of the survey. This left an analytic sample of 1,328 participants (rough response rate of 8.23%). Of these 1,328 responses, 99.8% of respondents completed the SSD scales, and 93% answered the item about conducting SRR. Pairwise deletion was thus used for analyses given the large remaining sample size, the cross-sectional nature of this study, and the small amounts of missing data for this study’s items (Schlomer et al., 2010).

**SSD Scale Validity.** A confirmatory factor analysis (CFA) was conducted using the Lavaan package in R software to examine the evidence for a three-factor structure of the SSD scale (Rosseel, 2012). This study used multiple indicators to assess model fit because universal cut-off points do not exist for fit indices (Bandalos & Gerstner, 2016). Adequate or good fit was
indicated by a root mean square error approximation (RMSEA) less than or equal to .06, a
standardized root mean square residual (SRMR) less than or equal to .08, and a Comparative Fit
Index (CFI) of at least .90 (Bentler, 1990; Hu & Bentler, 1999). The chi-square test was also
conducted and reported based on standard of practice; however, this test is not a reliable measure
of fit with large sample sizes (Gallagher et al., 2013). Standardized factor loadings were
interpreted based on Comrey and Lee (1992)’s guidelines: loadings greater than .70 were
considered excellent, .63 very good, .55 good, .45 fair, and .32 poor. It is important to note these
recommendations were made for exploratory factor analysis, but they may provide a rough
guideline for CFA studies (Distefano & Hess, 2005). Theoretical considerations, such as which
items were likely to be considered as “stigma” vs. “strengths,” also influenced decisions about
retention of items.

The three-factor model for the SSD was found to be an adequate fit relative to the
baseline mode ($\chi^2 = 3201.66$, df = 296, CFI = .917, RMSEA = .060, SRMR = .055). The
stigmatizing attitudes subscale correlated significantly with the strengths-based subscale ($r = -.74$, $p < .001$) and the disclosure views subscale ($r = -.36$, $p < .001$). The strengths-based
subscale also correlated with the disclosure views subscale ($r = .33$, $p < .001$).

Table 2 provides the standardized factor loadings (i.e., “Stdyx”) of the SSD items.
Averaging across all vignette groups, the standardized factor loadings for most items ($N=21$)
reached good to excellent levels. All items reached at least acceptable levels (Stdyx $\geq .456$) and
were retained for analyses. The standardized factor loadings were similar when subgrouping by
vignette. The items “biased” (Stdyx = .456), “pushing an agenda” (Stdyx = .503), “unique
perspective” (Stdyx = .492), “disclosure in a diversity statement” (Stdyx = .479), and “disclosure
in a positionality statement” (Stdyx = .532) were the worst performing items.
<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1: Stigmatizing Attitudes</th>
<th>Factor 2: Strengths-based Attitudes</th>
<th>Factor 3: Disclosure Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Biased</td>
<td>.456</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Irresponsible</td>
<td>.776</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Should pursue different topic</td>
<td>.724</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Selfish</td>
<td>.646</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5. Bad judgement</td>
<td>.768</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6. Less trustworthy</td>
<td>.742</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Pushing an agenda</td>
<td>.503</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8. Doing research for wrong reasons</td>
<td>.805</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>9. Admirable</td>
<td>-</td>
<td>.666</td>
<td>-</td>
</tr>
<tr>
<td>10. Motivation</td>
<td>-</td>
<td>.575</td>
<td>-</td>
</tr>
<tr>
<td>11. Insight</td>
<td>-</td>
<td>.569</td>
<td>-</td>
</tr>
<tr>
<td>12. Is a good role model</td>
<td>-</td>
<td>.662</td>
<td>-</td>
</tr>
<tr>
<td>13. Should be accepted by academic community</td>
<td>-</td>
<td>.695</td>
<td>-</td>
</tr>
<tr>
<td>14. Research pursuit is meaningful</td>
<td>-</td>
<td>.723</td>
<td>-</td>
</tr>
<tr>
<td>15. Research pursuit is respectable</td>
<td>-</td>
<td>.745</td>
<td>-</td>
</tr>
<tr>
<td>16. Unique perspective</td>
<td>-</td>
<td>.492</td>
<td>-</td>
</tr>
<tr>
<td>17. Disclose publicly</td>
<td>-</td>
<td>-</td>
<td>.803</td>
</tr>
<tr>
<td>18. Disclose when giving talk</td>
<td>-</td>
<td>-</td>
<td>.777</td>
</tr>
<tr>
<td>19. Disclose to anyone in academia</td>
<td>-</td>
<td>-</td>
<td>.837</td>
</tr>
<tr>
<td>20. Disclose during campus interview</td>
<td>-</td>
<td>-</td>
<td>.802</td>
</tr>
<tr>
<td>21. Disclose in a personal statement</td>
<td>-</td>
<td>-</td>
<td>.753</td>
</tr>
<tr>
<td>22. Disclose in diversity statement</td>
<td>-</td>
<td>-</td>
<td>.479</td>
</tr>
<tr>
<td>23. Disclose on social media</td>
<td>-</td>
<td>-</td>
<td>.715</td>
</tr>
<tr>
<td>24. Disclose while teaching a class</td>
<td>-</td>
<td>-</td>
<td>.773</td>
</tr>
<tr>
<td>25. Disclose to an academic mentor</td>
<td>-</td>
<td>-</td>
<td>.683</td>
</tr>
<tr>
<td>26. Disclose in a positionality statement</td>
<td>-</td>
<td>-</td>
<td>.532</td>
</tr>
<tr>
<td><strong>Cronbach’s alpha</strong></td>
<td><strong>.860</strong></td>
<td><strong>.842</strong></td>
<td><strong>.907</strong></td>
</tr>
</tbody>
</table>
The SSD scale demonstrated acceptable internal consistency. Across the full sample, the reliability of each subscale was good: stigmatizing attitudes (Cronbach’s alpha = .860), strengths-based attitudes (Cronbach’s alpha = .842), and disclosure views (Cronbach’s alpha = .907). Reliability of the scales was similar when subgrouping by vignette.

The SSD scale also exhibited preliminary evidence of convergent validity. Convergent validity of the SSD scale with mental health stigma was examined by analyzing Pearson correlations \( r \) of each SSD subscale with established stigma measures of mental illness (i.e., Social Distance Scale; Fear/Avoidance subscale of the PPMI), three face-valid items that asked participants about the level of appropriateness for a researcher to talk about their personal connections to depression, and a one-item Feelings Thermometer about depression. Statistical significance of correlations was determined by an alpha of .01 \( (p < .01) \). The Feelings Thermometer item assessed attitudes about how “warm” or “cold” people feel toward people who have depression, with higher scores indicating warmer (i.e., more favorable) attitudes.

Among the sample of participants who were assigned to the depression vignettes \( (N = 496) \), each SSD subscale significantly correlated with the Social Distance Scale, the Fear/Avoidance subscale of the PPMI, and face-valid items that assessed perceptions of SRR on depression. The stigmatizing attitudes subscale correlated significantly with the Social Distance Scale \( (r = .22, p < .001, N = 419) \), PPMI Fear/Avoidance subscale scale \( (r = .24, p < .001, N = 420) \), and Feelings Thermometer about depression \( (r = -.29, p < .001, N = 400) \); the strengths-based attitudes subscale correlated significantly with the Social Distance Scale \( (r = -.14, p < .001, N = 419) \) and PPMI Fear/Avoidance subscale scale \( (r = -.19, p < .001, N = 420) \); and the disclosure views subscale correlated significantly with the Social Distance Scale \( (r = -.16, p < .001, N = 420) \) and PPMI Fear/Avoidance subscale scale \( (r = -.19, p = .001, N = 421) \). The three
single, face-valid items about SRR depression disclosure also correlated significantly with each SSD subscale \( (rs \geq .23, ps < .001) \).

Convergent validity of the SSD scale with cancer stigma was examined by analyzing Pearson correlations of each SSD subscale with four face-valid items that asked participants about the level of appropriateness for a researcher to talk about their personal connections to cancer, and a one-item Feelings Thermometer about cancer. The Feelings Thermometer item assessed attitudes about how “warm” or “cold” people feel toward people who have cancer, with higher scores indicating more favorable attitudes. Among the sample of participants who were assigned to the cancer vignettes \( (N = 508) \), each SSD subscale significantly correlated with the Feelings Thermometer about cancer: stigmatizing attitudes subscale \( (r = -.23, p < .001, N = 400) \), strengths-based attitudes subscale \( (r = .17, p < .001, N = 435) \), and disclosure views subscale \( (r = -.18, p < .001, N = 435) \). The four face-valid items about SRR cancer disclosure also correlated significantly with each SSD subscale \( (rs \geq .21, ps < .001) \).

Convergent validity of the SSD scale with LGB stigma was examined by analyzing Pearson correlations of each SSD subscale with three items that were measured using the Feelings Thermometer, and four face-valid items about SRR sexual orientation disclosure. The three Feelings Thermometer items assessed attitudes about how “warm” or “cold” people feel toward people who are lesbian (single item), gay (single item), and bisexual (single item). Among the sample of participants who were assigned to the sexual orientation vignettes \( (N = 499) \), each SSD subscale significantly correlated with the Feelings Thermometer about people who are gay: stigmatizing attitudes subscale \( (r = -.24, p < .001, N = 412) \), strengths-based attitudes subscale \( (r = .19, p < .001, N = 441) \), and disclosure views subscale \( (r = .17, p < .001, N = 499) \).
The face valid item about SRR disclosure of a gay person also correlated significantly with each SSD subscale ($rs \geq -0.33, ps < .001$).

**Alpha and Effect Size.** Two-tailed tests (alpha of .05) were used across analyses. Effect sizes were interpreted using Cohen’s $d$ for one-way ANOVAs (Norouzian & Plonsky, 2018). Cohen’s $d$ indicates the standardized difference between two means. In between-subject designs, Cohen’s $d$ is expressed as the percentage of the standard deviation (Lakens, 2013). It is important to consider contextual factors, such as study design and constructs of interest (e.g., attitudes), when interpreting effect sizes (Lakens, 2013). In experimental research that examines prejudicial attitudes, effect sizes are often small but can still have meaningful implications for real-world outcomes such as discrimination (Funder & Ozer, 2019). This study referenced empirically-derived benchmarks from prior attitudinal research to guide interpretation of effect sizes (see for review, Lovakov & Agadullina, 2021). In this context, Cohen’s $d$ values of 0.15, 0.36, and 0.65 were considered small, medium, and large effects, respectively.

**Sensitivity Power Analyses.** A power analysis did not inform the sample intended sample size for the following reasons. First, the primary goal of this study was to collect as large a sample of U.S. psychology faculty and students as possible, which was dependent on the number of respondents willing to take the survey (Lakens, 2023; https://psyarxiv.com/9d3yf/). Second, resource (e.g., lack of funding to pay each participant) and time restrictions (i.e., this is a dissertation study) played roles in how long the survey would remain open for participation. Given that an a priori power analysis was not used, I conducted a sensitivity power analysis, which emphasizes the precision of estimates, rather than detection of a statistical effect (Perugini et al., 2018). I conducted a sensitivity analysis for my primary research question of interest (Aim 3, $N = 658$ across two groups). Using G*Power3 with the settings for a one-way ANOVA (fixed
effects, omnibus), with an alpha of .05, and power of .80, the sensitivity power analysis suggests this study was powered to detect a critical $F$ value of 3.86 or above, which equates to a Cohen’s $d$ of .17.

**Hypothesis 1:** SRR will be more prevalent in clinical psychology subfields compared to non-clinical subfields. Clinical subfields will include clinical, counseling, school, and neuropsychology (CL) disciplines. Non-CL disciplines would include all non-CL disciplines (i.e., behavioral neuroscience, cognitive psychology, developmental psychology, experimental psychology, industrial and organizational psychology, and social psychology).

To assess hypothesis 1, group comparisons of SRR by psychology discipline (CL vs. non-CL) were conducted using crosstabulation and chi-square ($X^2$) significance tests.

**Hypothesis 2 (replication):** Psychologists and trainees will stigmatize SRR more than non-SRR across vignettes. A series of one-way ANOVAs examined the effect of SRR on each SSD scale: stigmatizing attitudes, strengths-based attitudes, and disclosure views. It was expected that psychologists and trainees would endorse more stigma toward the SRR vignettes compared to the non-SRR vignettes, and view disclosure (i.e., discussing how one became interested in their topic) as more inappropriate, but it was also expected that participants would endorse more positive attitudes on the strengths-based subscale for the SRR vignettes.

**Hypothesis 3:** Psychologists and trainees will stigmatize SRR on depression more than SRR on cancer and SRR on sexual orientation. To assess hypothesis 3, a series of one-way ANOVAs examined the effect of mental health research topic on each SSD subscale: stigmatizing attitudes, strengths-based attitudes, and disclosure views. This analysis compared the means of the SRR depression vignette with the SRR cancer and SRR sexual orientation vignettes. It was expected that psychologists and trainees would endorse more stigma toward the
SRR depression vignette on the stigmatizing attitudes and disclosure views subscales compared to the SRR cancer and SRR sexual orientation vignettes. It was also expected that participants would endorse more positive attitudes on the strengths-based subscale for the SRR cancer and SRR sexual orientation vignettes compared to the SRR depression vignette.

**Hypothesis 4: CL fields will stigmatize SRR on depression more than non-CL fields.**

To assess hypothesis 4, I sub-grouped participants who were assigned to the SRR depression vignettes, and then I ran a series of one-way ANOVAs to examine the effect of psychology discipline (CL area vs. non-CL area) on the stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales. It was expected that CL area psychologists and trainees would rate SRR on depression more negatively on the stigmatizing attitudes and disclosure views subscales compared to non-CL area psychologists and trainees. It was also expected that non-CL area psychologists and trainees would rate SRR on depression more positively on the strengths-based attitudes subscale compared to CL-area participants.

**Randomization.** Prior to analyses, I verified that randomization successfully occurred across the vignettes. Analyses of race, gender, sexual orientation, professional status, and SRRer status found no differences on these variables as a function of vignette condition ($p$s > .05).
CHAPTER 3: RESULTS

Sample Demographics

Table 3 and Table 4 provide demographic and professional characteristics. Of the full sample \((N = 1,313)\), most respondents identified as cisgender women (71%), were not transgender (97.2%), were non-Hispanic white (80.4%), and their identified sexual orientation was heterosexual/straight (68.7%). Overall, the sample’s demographics for gender and race/ethnicity are consistent with recently reported APA demographic data for both graduate students and psychologists (see APA, 2016; APA, 2022; APA, n.d.).

The professional status of participants was as follows: graduate student (59.0%, \(N = 773\)), faculty/academic researcher (35.9%, \(N = 470\)), “other” (2.7%, \(N = 35\)), and postdoctoral fellow (1.6%, \(N = 21\)). Among non-student participants, there was a good representation of professional roles across career status: Adjunct (1.0%, \(N = 5\)), Lecturer (2.3%, \(N = 12\)), Visiting Assistant Professor (0.2%, \(N = 1\)), Postdoctoral Fellow (3.8%, \(N = 20\)), Assistant Professor (22.7%, \(N = 119\)), Associate Professor (22.5%, \(N = 118\)), Full Professor (41.1%, \(N = 216\)), and “other” (6.5%, \(N = 34\)). Of graduate student participants, there was also good representation across years in training: First year (16.1%, \(N = 123\)), Second year (20.0%, \(N = 153\)), Third year (17.5%, \(N = 134\)), Fourth Year (17.9%, \(N = 137\)), Fifth year (17.5%, \(N = 134\)), Sixth year (8.5%, \(N = 65\)), and Seventh year or higher (2.5%, \(N = 19\)).

Across the full sample (\(N = 1,313\)), most participants identified their primary area as non-CL (\(n = 871, 66.5\%\)), and one third of participants identified in a primary CL area (\(n = 438, 33.5\%\)). There was a small but significantly higher prevalence of graduate student respondents
<table>
<thead>
<tr>
<th></th>
<th>SRRer</th>
<th>Non-SRRer</th>
<th>Full Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (M, SD)</strong></td>
<td>34.37 (11.91)</td>
<td>36.93 (13.82)</td>
<td>35.62 (12.98)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cisgender woman</td>
<td>515 (73.4)</td>
<td>364 (70.3)</td>
<td>932 (71.0)</td>
</tr>
<tr>
<td>Cisgender man</td>
<td>149 (21.2)</td>
<td>139 (26.8)</td>
<td>321 (24.24)</td>
</tr>
<tr>
<td>Non-binary / gender non-conforming</td>
<td>32 (4.6)</td>
<td>13 (2.5)</td>
<td>47 (3.6)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>6 (0.9)</td>
<td>2 (0.4)</td>
<td>13 (1.0)</td>
</tr>
<tr>
<td><strong>Are you transgender?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>683 (97.3)</td>
<td>504 (97.3)</td>
<td>1276 (97.2)</td>
</tr>
<tr>
<td>Yes</td>
<td>13 (1.9)</td>
<td>8 (1.5)</td>
<td>21 (1.6)</td>
</tr>
<tr>
<td>Unclear about question</td>
<td>1 (0.1)</td>
<td>0 (0)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>5 (0.7)</td>
<td>6 (1.2)</td>
<td>15 (1.1)</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>558 (79.5)</td>
<td>430 (83.0)</td>
<td>1055 (80.4)</td>
</tr>
<tr>
<td>Hispanic / Latinx</td>
<td>81 (11.5)</td>
<td>31 (6.0)</td>
<td>122 (9.3)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (1.1)</td>
<td>8 (1.5)</td>
<td>18 (1.4)</td>
</tr>
<tr>
<td>Asian / Asian-American</td>
<td>66 (9.4)</td>
<td>65 (12.5)</td>
<td>143 (10.9)</td>
</tr>
<tr>
<td>Black / African-American</td>
<td>49 (7.0)</td>
<td>13 (2.5)</td>
<td>67 (5.1)</td>
</tr>
<tr>
<td>Middle Eastern / North African</td>
<td>13 (1.9)</td>
<td>13 (2.5)</td>
<td>29 (2.2)</td>
</tr>
<tr>
<td>Native American / First Nations / Alaskan Native</td>
<td>9 (1.3)</td>
<td>2 (0.4)</td>
<td>12 (0.9)</td>
</tr>
<tr>
<td>Hawaiian / Pacific Islander</td>
<td>6 (0.9)</td>
<td>6 (0.9)</td>
<td>7 (0.5)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>6 (0.9)</td>
<td>8 (1.5)</td>
<td>18 (1.4)</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual / straight</td>
<td>442 (63.0)</td>
<td>389 (75.1)</td>
<td>902 (68.7)</td>
</tr>
<tr>
<td>Bisexual</td>
<td>132 (18.8)</td>
<td>66 (12.7)</td>
<td>209 (15.9)</td>
</tr>
<tr>
<td>Homosexual / gay / lesbian</td>
<td>52 (7.3)</td>
<td>17 (3.3)</td>
<td>71 (5.4)</td>
</tr>
<tr>
<td>Pansexual</td>
<td>39 (5.6)</td>
<td>13 (2.5)</td>
<td>52 (4.0)</td>
</tr>
<tr>
<td>Other</td>
<td>21 (3.0)</td>
<td>5 (1.0)</td>
<td>26 (2.0)</td>
</tr>
<tr>
<td>Asexual</td>
<td>5 (0.7)</td>
<td>11 (2.1)</td>
<td>16 (1.2)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>12 (1.7)</td>
<td>17 (3.3)</td>
<td>37 (2.8)</td>
</tr>
</tbody>
</table>

*Note: SRRer = any respondent who endorsed ever conducting SRR.*
Table 4: Professional Characteristics by History of Conducting Self-Relevant Research

<table>
<thead>
<tr>
<th>Professional Status</th>
<th>SRRer</th>
<th>Non-SRRer</th>
<th>Full Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Graduate Student</td>
<td>440 (62.7)</td>
<td>283 (54.6)</td>
<td>773 (59.0)</td>
</tr>
<tr>
<td>Postdoctoral Fellow</td>
<td>13 (1.9)</td>
<td>7 (1.4)</td>
<td>21 (1.6)</td>
</tr>
<tr>
<td>Faculty / Academic Researcher</td>
<td>219 (31.2)</td>
<td>213 (31.2)</td>
<td>470 (35.9)</td>
</tr>
<tr>
<td>Clinician</td>
<td>4 (0.6)</td>
<td>7 (1.4)</td>
<td>11 (0.8)</td>
</tr>
<tr>
<td>Other</td>
<td>26 (3.7)</td>
<td>8 (1.5)</td>
<td>35 (2.7)</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>3 (0.2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job Title (non-students only)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SRRer</td>
<td>Non-SRRer</td>
<td>Full Sample</td>
</tr>
<tr>
<td>Adjunct</td>
<td>4 (1.6)</td>
<td>0 (0)</td>
<td>5 (1.0)</td>
</tr>
<tr>
<td>Lecturer</td>
<td>5 (1.9)</td>
<td>6 (2.6)</td>
<td>12 (2.3)</td>
</tr>
<tr>
<td>Visiting Assistant Professor</td>
<td>1 (0.4)</td>
<td>0 (0)</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td>Postdoctoral fellow</td>
<td>12 (4.7)</td>
<td>7 (3.1)</td>
<td>20 (3.8)</td>
</tr>
<tr>
<td>Assistant Professor</td>
<td>58 (22.6)</td>
<td>54 (23.7)</td>
<td>119 (22.7)</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>63 (24.5)</td>
<td>48 (21.1)</td>
<td>118 (22.5)</td>
</tr>
<tr>
<td>Full Professor</td>
<td>91 (35.4)</td>
<td>104 (45.6)</td>
<td>216 (41.1)</td>
</tr>
<tr>
<td>Other</td>
<td>23 (8.9)</td>
<td>9 (3.9)</td>
<td>34 (6.5)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of Training (students only)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SRRer</td>
<td>Non-SRRer</td>
<td>Full Sample</td>
</tr>
<tr>
<td>First year</td>
<td>76 (17.5)</td>
<td>34 (12.1)</td>
<td>123 (16.1)</td>
</tr>
<tr>
<td>Second year</td>
<td>78 (17.9)</td>
<td>65 (23.1)</td>
<td>153 (20.0)</td>
</tr>
<tr>
<td>Third year</td>
<td>74 (17.0)</td>
<td>48 (17.1)</td>
<td>134 (17.5)</td>
</tr>
<tr>
<td>Fourth year</td>
<td>74 (17.0)</td>
<td>57 (20.3)</td>
<td>137 (17.9)</td>
</tr>
<tr>
<td>Fifth year</td>
<td>79 (18.2)</td>
<td>50 (17.8)</td>
<td>134 (17.5)</td>
</tr>
<tr>
<td>Sixth year</td>
<td>43 (9.9)</td>
<td>20 (7.1)</td>
<td>65 (8.5)</td>
</tr>
<tr>
<td>Seventh year or higher</td>
<td>11 (2.5)</td>
<td>7 (2.5)</td>
<td>19 (2.5)</td>
</tr>
</tbody>
</table>

Note: SRRer = any respondent who endorsed ever conducting SRR.

from CL areas ($n = 280, 66.5\%$) compared to graduate students from non-CL areas (60.0\%, 491), \(\chi^2(1, N = 1,240) = 5.08, p = .02\).

The distribution of psychology fields is as follows (note, participants could select more than one area): clinical ($n = 497, 37.9\%$), counseling ($n = 44, 3.4\%$), school ($n = 27, 2.1\%$), neuropsychology ($n = 46, 3.5\%$), rehabilitation ($n = 2, 0.2\%$), social ($n = 244, 18.6\%$), personality ($n = 47, 3.7\%$), IO ($n = 57, 4.3\%$), cognitive ($n = 208, 15.8\%$), neuroscience ($n =
185, 14.1%), educational (n = 22, 1.7%), community (n = 22, 1.7%), developmental (n = 188, 14.3%), health (n = 93, 7.1%), human factors (n = 18, 1.4%), forensic (n = 24, 1.8%), cultural (n = 23, 1.8%), and other (n = 134, 10.2%).

**Aim 1: Compare the prevalence of SRR across psychology disciplines**

Of all respondents who answered the SRR item (N = 1,230), more than one third (39.3%) reported currently doing SRR. By comparison, slightly less than a fifth (18.1%) reported doing SRR in the past, and less than half of the sample (42.5%) reported never having done SRR.

Overall, more than half of participants (57.4%) endorsed having conducted SRR. Of participants who endorsed doing SRR (N = 702), 80.9% had a lived experience that was connected to their research topic, and 62.3% had a close connection that was connected to their research topic (e.g., a researcher who studies depression and has a close friend or family member with the condition).

Graduate students were significantly more likely to report having conducted SRR (60.9%, total N = 723) compared to faculty (50.7%, total N = 432), χ²(1, N = 1,155) = 11.40, p < .001.

Of SRR participants with a **lived experience** related to their research topic and who answered follow-up questions about SRR (N = 568), 49.1% did SRR on mental health topics, 9.2% did SRR on physical health topics, 26.2% did SRR on race and ethnicity topics, 26.1% did SRR on gender topics, 21.8% did SRR on sexual orientation topics, 9.9% did SRR on neurodivergence topics, 9.0% did SRR on disability topics, 12.1% did SRR on parenting and caregiving topics, 8.6% did SRR on religious and spirituality topics, 0.9% did SRR on military and veteran topics, and 19.5% did some “other” type of SRR.

Of SRR participants with a **close connection** related to their research topic and who answered follow-up questions about SRR (N = 437), 59.5% did SRR on mental health topics, 20.8% did SRR on physical health topics, 30.0% did SRR on race and ethnicity topics, 29.1%
did SRR on gender topics, 23.1% did SRR on sexual orientation topics, 14.2% did SRR on disability topics, 12.1% did SRR on neurodivergence topics, 5.7% did SRR on military and veteran topics, 19.5% did SRR on parenting and caregiving topics, 7.3% did SRR on religious and spirituality topics, 12.6% did some “other” type of SRR.

Table 5: Prevalence of SRR by Psychology Area

<table>
<thead>
<tr>
<th>Field</th>
<th>SRR % (N)</th>
<th>Non-SRR % (N)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary clinical</td>
<td>68.6 (278)</td>
<td>31.4 (127)</td>
<td>405</td>
</tr>
<tr>
<td>Primary non-clinical</td>
<td>52.0 (423)</td>
<td>48.0 (390)</td>
<td>813</td>
</tr>
<tr>
<td>Counseling</td>
<td>76.2 (32)</td>
<td>23.8 (10)</td>
<td>42</td>
</tr>
<tr>
<td>Community</td>
<td>71.4 (15)</td>
<td>28.6 (6)</td>
<td>21</td>
</tr>
<tr>
<td>Clinical</td>
<td>69.4 (322)</td>
<td>30.6 (142)</td>
<td>464</td>
</tr>
<tr>
<td>Cultural</td>
<td>65.2 (15)</td>
<td>34.8 (8)</td>
<td>23</td>
</tr>
<tr>
<td>Educational</td>
<td>65.2 (15)</td>
<td>34.8 (8)</td>
<td>23</td>
</tr>
<tr>
<td>Health</td>
<td>64.4 (58)</td>
<td>35.6 (32)</td>
<td>90</td>
</tr>
<tr>
<td>Social</td>
<td>63.9 (152)</td>
<td>36.1 (86)</td>
<td>238</td>
</tr>
<tr>
<td>Other</td>
<td>58.3 (74)</td>
<td>41.7 (53)</td>
<td>127</td>
</tr>
<tr>
<td>Personality</td>
<td>54.5 (24)</td>
<td>45.5 (20)</td>
<td>44</td>
</tr>
<tr>
<td>Industrial-organizational</td>
<td>51.9 (27)</td>
<td>48.1 (25)</td>
<td>52</td>
</tr>
<tr>
<td>Forensic</td>
<td>50 (12)</td>
<td>50 (12)</td>
<td>24</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>50 (1)</td>
<td>50 (1)</td>
<td>2</td>
</tr>
<tr>
<td>Developmental</td>
<td>49.7 (89)</td>
<td>50.3 (90)</td>
<td>179</td>
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<tr>
<td>Neuroscience</td>
<td>43.0 (71)</td>
<td>57.0 (94)</td>
<td>165</td>
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<tr>
<td>Human factors</td>
<td>37.5 (6)</td>
<td>62.5 (10)</td>
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<tr>
<td>School</td>
<td>36.0 (9)</td>
<td>64.0 (16)</td>
<td>25</td>
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<tr>
<td>Neuropsychology</td>
<td>35.0 (14)</td>
<td>65.0 (26)</td>
<td>40</td>
</tr>
<tr>
<td>Cognitive</td>
<td>34.9 (67)</td>
<td>65.1 (125)</td>
<td>192</td>
</tr>
</tbody>
</table>

Note: SRR = any respondent who endorsed ever conducting SRR. Dark shading = clinical fields. Light shading = non-clinical fields. Participants could select multiple fields for the non-primary fields, so the total N does not equate to the sample size of the study.

The prevalence of SRR varied significantly by primary psychology discipline (see Table 5). Consistent with hypothesis 1, primary area CL participants (68.6%, total N = 407) were significantly more likely to conduct SRR than primary non-CL participants (52.0%, total N = 821), $\chi^2(1, N = 1,228) = 30.46, p < .001$. For descriptive purposes, the prevalence of SRR by discipline is the following: counseling (76.2%, total N = 42), community (71.4%, total N = 21), clinical (69.4%, total N = 464), educational (65.2%, total N = 23), cultural (65.2%, total N = 23),
health (64.4%, total N = 90), social (63.9%, total N = 238), other (58.3%, total N = 127), personality (54.5%, total N = 44), industrial-organizational (51.9%, total N = 52), forensic (50%, total N = 24), rehabilitation (50%, total N = 2), developmental (49.7%, total N = 179), neuroscience (43.0%, total N = 165), human factors (37.5%, total N = 16), school (36%, total N = 25), neuropsychology (35%, total N = 40), and cognitive (34.9%, total N = 192, total N = 192). For the latter numbers, please note that the small sample sizes for many of the disciplines are likely to be unreliable, so inferential statistical tests were not conducted. Overall, hypothesis 1 was supported: CL psychologists and trainees had higher rates of SRR compared to non-CL faculty and graduate students.

**Aim 2 (replication): Compare perceptions of SRR vs. non-SRR**

In a previous study with CL psychologists and trainees, vignettes depicting SRR were viewed more negatively with respect to the stigmatizing attitudes and disclosure views compared to a vignette depicting non-SRR (Devendorf et al., 2023). Additionally, the SRR vignette was viewed more positively on the strengths-based attitudes subscale compared to the non-SRR vignette (Devendorf et al., 2023). Here we sought to investigate if this finding replicates in a broader sample of psychology subfields. Thus, I ran a series of one-way ANOVAs to examine the effect of SRR (SRR vs. non-SRR) on the stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales. This analysis collapsed across the specific content vignettes that depicted both SRR (i.e., depression, cancer, sexual orientation) and non-SRR. Table 6 provides the means and standard deviations of the vignettes on the SSD scale. Note, a two-way ANOVA was also conducted on aims 2-4 and yielded similar results. For brevity, only the results of the ANOVAs are presented in this document.
Results illustrate that psychologists and trainees did not endorse higher stigmatizing attitudes toward hypothetical self-relevant researchers \((N = 652, M = 1.88, SD = 0.59)\) than toward a hypothetical non-self-relevant researcher \((N = 661, M = 1.86, SD = 0.54)\), \(F(1, 1,311) = .395, p = .530\), with a negligible effect size \((d = 0.03, 95\% \text{ confidence interval } [CI] = [-0.07, 0.14])\). In other words, when collapsing across research topics, there was no evidence that psychologists and trainees rated hypothetical self-relevant researchers as more biased, selfish, and prone to bad judgments than a hypothetical non-self-relevant researcher.

### Table 6: Means and Standard Deviations of the Stigma, Strengths, and Disclosure Scale

<table>
<thead>
<tr>
<th>SSD Scale</th>
<th>Vignette</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stigmatizing attitudes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SRR dep</td>
<td>1.96</td>
<td>0.61</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>SRR can</td>
<td>1.87</td>
<td>0.58</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>SRR sex</td>
<td>1.83</td>
<td>0.58</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td>Non-SRR dep</td>
<td>1.86</td>
<td>0.52</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>Non-SRR can</td>
<td>1.81</td>
<td>0.55</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>Non-SRR sex</td>
<td>1.92</td>
<td>0.54</td>
<td>209</td>
</tr>
<tr>
<td></td>
<td>Strengths-based attitudes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SRR dep</td>
<td>4.13</td>
<td>0.50</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>SRR can</td>
<td>4.28</td>
<td>0.52</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>SRR sex</td>
<td>4.27</td>
<td>0.51</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td>Non-SRR dep</td>
<td>3.64</td>
<td>0.43</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>Non-SRR can</td>
<td>3.73</td>
<td>0.44</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>Non-SRR sex</td>
<td>3.68</td>
<td>0.48</td>
<td>209</td>
</tr>
<tr>
<td></td>
<td>Disclosure views</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SRR dep</td>
<td>3.54</td>
<td>0.64</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>SRR can</td>
<td>3.87</td>
<td>0.62</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>SRR sex</td>
<td>3.90</td>
<td>0.68</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td>Non-SRR dep</td>
<td>3.91</td>
<td>0.63</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td>Non-SRR can</td>
<td>3.94</td>
<td>0.58</td>
<td>221</td>
</tr>
<tr>
<td></td>
<td>Non-SRR sex</td>
<td>3.89</td>
<td>0.64</td>
<td>209</td>
</tr>
</tbody>
</table>

*Note: SRR = self-relevant research; dep = depression; can = cancer; sex = sexual orientation. Higher scores on the stigmatizing attitudes scale indicate more stigma. Higher scores on the strengths-based attitudes scale indicate more positive attitudes. Higher scales on the disclosure views subscale indicate more positive attitudes toward disclosure (i.e., discussing one’s reason for pursuing a research topic). All scales range from 1 to 5.*

Results did show evidence that psychologists and trainees disapproved of disclosure (i.e., discussing one’s reason for interest in a research area) of SRR compared to non-SRR. An
ANOVA revealed that psychologists and trainees viewed disclosure of non-SRR as more appropriate ($N = 661, M = 3.91, SD = 0.62$) compared to disclosure of SRR ($N = 652, M = 3.78, SD = 0.67$), $F(1, 1,311) = 13.996, p < .001$, with a small effect size ($d = 0.21, 95\% CI = [0.10, 0.32]$). In other words, when collapsing across research topics, psychologists and trainees are more likely to view disclosure of SRR as inappropriate in contexts like a personal statement, job talk, and research conference.

Finally, psychologists and trainees rated a hypothetical self-relevant researcher ($N = 652, M = 4.23, SD = 0.51$) more highly on the strengths-based attitudes subscale than a hypothetical non-self-relevant researcher ($N = 661, M = 3.68, SD = 0.51$), $F(1, 1,311) = 423.97, p < .001$, with a large effect size ($d = 1.14, 95\% CI = [1.02, 1.25]$), meaning that hypothetical self-relevant researchers were regarded as more admirable, motivated, and insightful. In summary, 2 of the 3 findings from the original Devendorf et al. (2023) study replicated in a broader sample of psychologists and trainees. There was no evidence in this study that psychologists and trainees held more stigmatizing attitudes about SRR when collapsing across research topics, although disclosure of SRR was viewed more negatively. There was also evidence that psychologists and trainees held more strengths-based attitudes about SRR compared to non-SRR. Overall, hypothesis 2 had substantial support.

**Aim 3: Compare attitudes about SRR on mental illness versus SRR on other identity-related constructs**

In Devendorf et al. (2023), attitudes about SRR depended on the specific research topic, in which vignettes depicting SRR on mental health topics were viewed more negatively on the stigmatizing attitudes and disclosure views subscales compared to a vignette depicting SRR on a physical health condition (i.e., cancer; Devendorf et al., 2023). Additionally, the study found that
the SRR vignette on cancer was viewed more positively on the strengths-based attitudes subscale compared to the SRR vignettes on mental health topics (Devendorf et al., 2023). Given that CL psychologists and trainees viewed SRR on mental health topics more negatively than SRR on physical health topics, the current study used a broader sample of psychologists and trainees to contrast SRR on mental health topics (i.e., depression) with other SRR on social identities (i.e., sexual orientation) and SRR on physical health topics (i.e., cancer).

To examine this issue, I ran a series of one-way ANOVAs to examine the effect of SRR research topic (i.e., mental health SRR vs. non-mental health SRR) on the stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales. This analysis collapsed the non-mental health SRR vignettes (i.e., SRR cancer and SRR sexual orientation) and compared them with the SRR depression vignette. This analysis yielded evidence that psychologists and trainees were more likely to stigmatize hypothetical self-relevant researchers on depression ($N = 204, M = 1.97, SD = 0.63$) compared to hypothetical non-mental health self-relevant researchers ($N = 454, M = 1.85, SD = 0.58$), $F(1, 656) = 6.478, p = .011$, with a small effect size ($d = 0.21, 95\% \text{ CI} = [0.05, 0.38]$). In other words, when comparing SRR depression vs. SRR on cancer and SRR orientation, a broad sample of psychologists and trainees rated hypothetical mental health self-relevant researchers as more biased, selfish, and prone to bad judgments than a hypothetical non-mental health self-relevant researcher.

Results also provided evidence that psychologists and trainees disapproved of disclosure (i.e., discussing one’s reason for interest in a research area) of SRR on depression compared to SRR on cancer and SRR on sexual orientation. An ANOVA revealed that psychologists and trainees viewed disclosure of SRR on non-mental health topics as more appropriate ($N = 452, M = 3.88, SD = 0.66$) compared to disclosure of SRR of depression ($N = 205, M = 3.54, SD = 0.50$),
\[ F(1, 655) = 39.186, p < .001, \text{ with a medium to large effect size } (d = .53, 95\% \text{ CI} = [0.36, 0.69]). \]

This finding suggests that psychologists and trainees are more likely to view disclosure of SRR on mental health topics as more inappropriate in contexts like a personal statement, job talk, and research conference compared to disclosure of SRR on non-mental health topics.

Finally, psychologists and trainees rated a hypothetical non-mental health self-relevant researcher \((N = 454, M = 4.27, SD = 0.51)\) more highly on the strengths-based attitudes subscale than a hypothetical depression self-relevant researcher \((N = 205, M = 4.12, SD = 0.51)\), \(F(1, 657) = 12.082, p < .001, \text{ with a small to medium effect size } (d = 0.29, 95\% \text{ CI} = [0.13, 0.46])\), meaning that hypothetical non-mental health self-relevant researchers (who studied cancer or sexual orientation) were regarded as more admirable, motivated, and insightful than a hypothetical depression self-relevant researcher.

In a preliminary attempt to explain the higher stigma toward SRR on depression, I conducted paired sample \(t\)-tests to see if psychologists and trainees had more negative overall feelings about people with depression compared to people who have cancer and people who are gay; only these comparisons were conducted because they mirrored the hypothetical researchers that were depicted in the vignettes. Table 7 provides the descriptive statistics for this measure.

**Table 7: Measurement of the Feelings Thermometer \((N = 1,215)\)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
<th>Skew</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with depression</td>
<td>23.00</td>
<td>100</td>
<td>87.24</td>
<td>16.83</td>
<td>-1.25</td>
<td>.45</td>
</tr>
<tr>
<td>People with cancer</td>
<td>17.00</td>
<td>100</td>
<td>89.57</td>
<td>15.76</td>
<td>-1.51</td>
<td>1.17</td>
</tr>
<tr>
<td>People who are gay</td>
<td>40.00</td>
<td>100</td>
<td>90.28</td>
<td>15.76</td>
<td>-1.61</td>
<td>1.31</td>
</tr>
<tr>
<td>People who are lesbian</td>
<td>41.00</td>
<td>100</td>
<td>90.28</td>
<td>15.65</td>
<td>-1.60</td>
<td>1.27</td>
</tr>
<tr>
<td>People who are bisexual</td>
<td>45.00</td>
<td>100</td>
<td>90.02</td>
<td>15.90</td>
<td>-1.56</td>
<td>1.11</td>
</tr>
</tbody>
</table>

*Note:* Higher scores indicate more favorable attitudes. Possible scores range from 0 to 100.

On these single-item scales, results show that psychologists and trainees had significantly worse feelings about people with depression compared to people who are gay \((M \text{ Difference} = -3.03, SD \text{ Difference} = 9.29), t(1,214) = -11.38, p < .001, \text{ with a small effect size } (d = 0.33).\)
Psychologists also had significantly worse feelings about people with depression compared to people with cancer \((M \text{ Difference} = -2.32, SD \text{ Difference} = 7.98), t(1,214) = -10.16, p < .001\), with a small effect size \((d = 0.29)\). Additionally, psychologists and trainees had significantly worse feelings about people with cancer compared to people who are gay \((M \text{ Difference} = -0.70, SD \text{ Difference} = 9.19), t(1,214) = -2.69, p = .007\), although this effect size was negligible \((d = 0.08)\).

In summary, hypothesis 3 was supported: SRR on depression was viewed more negatively on the stigmatizing attitudes and disclosures view subscales, and SRR on cancer and SRR sexual orientation were viewed more positively on the strengths-based attitudes subscale. From preliminary analyses, these findings could be accounted for, in part, by the relatively worse overall negative attitudes about people with depression compared to the other identities.

**Aim 4: Investigate if CL psychologists and trainees hold more negative attitudes about SRR on mental illness compared to non-CL psychologists and trainees**

Given the differences in psychology training and expertise, I sought to understand whether faculty and graduate students in CL fields compared to non-CL fields differ their attitudes about SRR on mental health topics. Among the participants who were assigned the SRR depression vignette, I ran a series of one-way ANOVAs to examine the effect of psychology discipline (CL area vs. non-CL area) on the stigmatizing attitudes, strengths-based attitudes, and disclosure views subscales.

Results did not show evidence of differential attitudes about SRR on depression across the three subscales. CL psychologists and trainees scored similarly on the stigmatizing attitudes subscale \((N = 64, M = 1.92, SD = 0.65)\) compared to non-CL psychologists and trainees \((N = 137, M = 1.97, SD = 0.58), F(1, 199) = .271, p = .603\), with a negligible to small effect size \((d =\)
CL psychologists and trainees also did not differ on the disclosure views subscale \((N = 64, M = 3.44, SD = 0.64)\) compared to non-CL psychologists and trainees \((N = 137, M = 3.58, SD = 0.64)\), \(F(1, 199) = 2.037, p = .155\), with a negligible to medium effect size \((d = 0.22, 95\% CI = [-0.08, 0.51])\). Lastly, CL psychologists and trainees did not statistically differ on the strengths-based attitudes subscale \((N = 64, M = 4.11, SD = 0.53)\) compared to non-CL psychologists and trainees \((N = 137, M = 4.14, SD = 0.64)\), \(F(1, 199) = .141, p = .707\), with a negligible to small effect size \((d = 0.06, 95\% CI = [-0.24, 0.35])\).

To further explore if there are attitude differences toward the studied identity groups by psychology area, I ran a series of ANOVAs to examine the effect of psychology discipline (CL area vs. non-CL area) on the Feelings Thermometer for each identity. Results revealed that CL psychologists had significantly more favorable attitudes about people who have depression, people who are gay, and people who have cancer compared to non-CL psychologists (see Table 8), \(ps < .01\).

<table>
<thead>
<tr>
<th>Identity</th>
<th>Primary Area</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>(F)-value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>People with depression</td>
<td>Clinical</td>
<td>420</td>
<td>89.12</td>
<td>14.95</td>
<td>8.26</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>Non-Clinical</td>
<td>793</td>
<td>86.21</td>
<td>17.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who are gay</td>
<td>Clinical</td>
<td>420</td>
<td>92.44</td>
<td>13.73</td>
<td>12.44</td>
<td>&lt; .001</td>
</tr>
<tr>
<td></td>
<td>Non-Clinical</td>
<td>793</td>
<td>89.10</td>
<td>16.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People with cancer</td>
<td>Clinical</td>
<td>420</td>
<td>91.23</td>
<td>14.33</td>
<td>7.30</td>
<td>.007</td>
</tr>
<tr>
<td></td>
<td>Non-Clinical</td>
<td>793</td>
<td>88.66</td>
<td>16.42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Higher scores indicate more favorable attitudes. Possible scores range from 0 to 100.

Overall, hypothesis 4 was not supported. There was no evidence that CL oriented faculty and trainees viewed SRR on a mental health topic more negatively than their non-clinical counterparts. In fact, on overall attitudes, CL psychologists and trainees actually had more favorable attitudes than non-CL psychologists and trainees regarding people with depression, cancer, and who are gay.
CHAPTER 4: DISCUSSION

A primary aim of this project was to examine the prevalence and perceptions of self-relevant research in a large sample of faculty and graduate students drawn from U.S. doctoral programs in psychology. Prior to this project, the relevant database was limited to anecdotal examples of psychologists discussing their personal experiences in relation to their research (e.g., Linehan, 2021; Schleider, 2023; Hinshaw, 2017; Rottenberg, 2014), and a single empirical study (Devendorf et al. 2023) focused only on clinical, counseling, and school psychologists and trainees. Understanding how common SRR is across psychology fields – and how it is viewed – can help identify if there are challenges or advantages for psychologists and trainees with lived experiences. Findings from this study can thus enrich ongoing conversations about the inclusion of researchers with lived experience in psychology research (Hawke et al., 2022).

Across psychology fields SRR was observed to be more often the norm than the exception: 57.4% of participants reported conducting SRR. This high rate suggests that lived experience may be a powerful motivator for pursuing specific research topics in psychology. Notably, SRR was significantly more prevalent among graduate students (60.9%) than faculty (50.7%). Although no data were collected that can explain this difference, there are at least three plausible explanations. First, it is possible that rates of SRR have increased over time because of generational effects. Graduate programs in psychology continue to be increasingly competitive (APA, 2016; Michalski et al., 2017), as it is common for prospective students to apply over the span of multiple years (Prinstein, 2022). Thus, prospective students who have more intrinsic motivation and personal interests in pursuing their research may be more resilient to this
admissions process (Ommering et al., 2018). Second, it is possible that psychologists who do SRR are selected out of academia over time. For example, to sustain a viable research career in psychology, one must prioritize obtaining grant funding (Burrow-Sanchez et al., 2016; Drotar, 2013), which may require a researcher to shift or alter their research and career interests and priorities over time. Lastly, it is possible that a small proportion of the differences between graduate students and faculty simply reflect the current sample’s area differences; there was a small but statistically significant higher rate of graduate students (66.5%) from CL fields compared to non-CL fields (60.0%).

Given that psychology fields differ in their training and content areas, it was hypothesized that people in CL fields (i.e., clinical, counseling, school, and neuropsychology fields) would report higher rates of SRR than people in non-CL fields (i.e., behavioral neuroscience, cognitive psychology, developmental psychology, experimental psychology, industrial and organizational psychology, and social psychology). CL fields were expected to exhibit higher rates of SRR because having experiences with, or connections to, mental health difficulties are often construed as identity-related experiences that may motivate interest in a subject. For many people who have mental health difficulties, these challenges can be chronic, impairing, and, as a result, life-changing (e.g., Cruwys & Gunaseelen, 2016). Additionally, mental health difficulties are personal experiences that can be treated or supported by trained professionals, and thus having had experience with them may motivate one to do research to help others. Consistent with Hypothesis 1, participants in CL fields (68.6%) reported a higher SRR prevalence rate compared to participants in non-CL fields (52.0%). Moreover, consistent with the rationale for hypothesis 1, the most common type of SRR among people who conducted SRR was SRR on mental health topics. Thus, findings about the prevalence of SRR broadly replicated
the only previous study of SRR in a sample of clinical, counseling, and school psychologists and trainees (Devendorf et al., 2023), which estimated SRR to be 54.6% in the full sample, and SRR on mental health topics was found in 52.4% of people who had done SRR.

The second aim of this project was to understand perceptions of SRR, including how SRR perceptions might vary by SRR research topic and psychology discipline. In a previous study with clinical, counseling, and school psychologists and trainees (Devendorf et al., 2023), participants were more likely to hold stigmatizing attitudes (e.g., research pursuit is biased, selfish, and irresponsible) toward a hypothetical researcher who did SRR compared to a hypothetical researcher who did not do SRR; disclosure of SRR was also viewed as more inappropriate than non-SRR, but the hypothetical SRRer was also viewed as having more strengths (e.g., being admirable, motivated, serving as positive role model).

In the current investigation with a broader sample of psychologists and trainees and stronger methodological design, this study sought to replicate and extend these original findings. Overall, 2 of the 3 findings from Devendorf et al. (2023) conceptually replicated in the current sample of psychologists and trainees. Contra Devendorf et al (2023), there was no evidence in this study that psychologists and trainees held more stigmatizing attitudes about SRR when collapsing across research topics, although disclosure of SRR was viewed more negatively. Indeed, in the present sample psychologists and trainees held more strengths-based attitudes about SRR compared to non-SRR. These positive attitudes are consistent with the perspectives that lived experience can be used as a strength in research (e.g., Hawke et al., 2021; Victor et al., 2020). Several possibilities may explain the null effects on the stigmatizing attitudes scale in the current study. On one hand, this null finding may be interpreted at face value: when collapsing across mental health, physical health, and sexual orientation research topics, psychologists and
trainees do not hold more negative attitudes about SRR compared to non-SRR. However, it is also possible that the methodological differences (e.g., different research topics of vignettes, added items in scales) and sampling differences across the studies explain the difference in effects.

Of note, given that previous research shows the type of SRR can impact perceptions of SRR (Altenmüller et al., 2021; Devendorf et al., 2023; Thai et al., 2021), the current study examined whether SRR on mental health topics (i.e., depression) was viewed differently than SRR on other identity related constructs (i.e., SRR on cancer; SRR on sexual orientation). It was hypothesized that psychologists and trainees would endorse more stigma toward the SRR depression vignette on the stigmatizing attitudes and disclosure views subscales compared to the SRR cancer and SRR sexual orientation vignettes. Additionally, it was expected that the SRR cancer and SRR sexual orientation vignettes would be viewed with more strengths-based attitudes. In summary, this hypothesis was supported: SRR on depression was viewed more negatively on the stigmatizing attitudes and disclosures views subscales, and SRR on cancer and SRR sexual orientation was viewed more positively on the strengths-based attitudes subscale. These differences may be explained, to a small extent, by the findings from the Feeling Thermometer that psychologists and trainees had overall less favorable attitudes about people with depression compared to the other identity groups. This finding, however, should be interpreted with some caution, as the Feelings Thermometer had a higher number of outliers, which may suggest respondents experienced confusion while taking this scale. Still, outliers were removed from the analysis, and the measure was delivered to a large sample, which may provide some confidence in the observed differences.
Therefore, while it is difficult to explain why these different perceptions of SRR exist between mental and non-mental health topics from this data collection alone, there are several possibilities. For example, the finding that an SRRer on depression is more stigmatized from a disclosure standpoint may reflect that mental health conditions – in an academic psychology research context – are relatively more stigmatized identities than having a physical illness, like cancer, or being a sexual minority. In large survey studies, lay people commonly associate depressed people with negative stereotypes like being dangerous, being unpredictable, being difficult to talk to, and being unlikely to recover (Devendorf et al., 2020; Pescosolido et al., 2021; Wood et al. 2014). People are also more likely to be blamed for having depression, as their illness may be viewed as more controllable relative to physical illnesses (Monteith & Pettit, 2011). It is thus conceivable that negative beliefs about depression as a topic may contribute to why we observed more negative attitudes toward a depression SRRer compared SRRers on cancer topics or sexual orientation topics. Another consideration is that prior research has found that when lay people have favorable attitudes about LGB identities, they are more likely to view a gay researcher as more credible and trustworthy compared to a non-gay researcher on LGB topics (Altenmüller et al., 2021). Given that psychology is a relatively supportive field of LGB identities, evidenced by ongoing DEI efforts and the high prevalence of LGB identities (e.g., 20% of the current study’s sample identified as LGB), it is not surprising that psychologists and trainees also had relatively more positive attitudes about SRR on sexual orientation topics compared to SRR on depression.

Since depression was the only mental health topic in this study, whether this pattern of results would generalize to other mental health conditions is uncertain. Nevertheless, depression was a fair topic to test the hypothesis for several reasons. First, depression is among the top three
most common mental health difficulties among psychologists and trainees (Hill et al., 2022; Tay et al., 2018; Victor et al., 2022b); one study found that over 50% of respondents from CL programs endorsed a history of depression (Victor et al., 2022b). Second, depression could be seen as a less stigmatized condition compared to other mental health conditions, such as schizophrenia and substance use disorders (Wood et al. 2014). Furthermore, research has shown that public stigma toward depression has declined over the last 30 years (Pescosolido et al., 2021). Consistent with these ideas, Devendorf et al. (2023) found that depression SRR was less stigmatized than SRR on schizophrenia and suicide. Given the current study found evidence of stigma toward SRR on depression compared to SRR on cancer and SRR on sexual orientation topics, it is reasonable to predict that SRR on other mental health topics would be no less stigmatized that what was observed for SRR on depression.

Lastly, this study examined if psychologists and trainees from CL fields compared to non-CL fields held more negative attitudes, and fewer positive attitudes, about SRR on depression. Given that CL psychologists and trainees are more likely to interact with more severe forms of mental illness (i.e., “the clinician’s illusion”; Vessey et al., 1994), they were hypothesized to have more negative attitudes about SRR on depression. The data did not support this hypothesis, suggesting that CL and non-CL psychologists and trainees do not differ in their attitudes about depression. In fact, when comparing overall attitudes about people with depression, people who have cancer, and people who are gay, CL psychologists had more favorable attitudes compared to non-CL psychologists. This trend across findings may provide evidence that CL psychologists, as trained mental health providers, have small but relatively more compassion, acceptance, and openness toward these identity groups.
Implications for Psychology

This study revealed that SRR is common across faculty and graduate students at U.S. doctoral programs in psychology. Most psychologists and trainees reported having conducted SRR, and many have conducted SRR on mental health topics, racial and ethnicity topics, and sexual orientation topics. Although SRR is common, disclosure of SRR was still viewed as more inappropriate compared to non-SRR, and SRR on depression was viewed more negatively than SRR on cancer and SRR on sexual orientation. These differential attitudes put psychologists who do SRR in a precarious position, as they may have to weigh the risks and benefits of disclosure during professional contexts.

As a matter of professional development, psychology researchers are routinely asked, “How did you become interested in your research topic?” This question may appear in formal contexts like graduate school, scholarship, and grant applications (Prinstein, 2022), or may even come up during casual networking conversations, such as a discussion with a potential mentor. While such questions are fair, they also may create vulnerability for respondents if their reason for pursuing their research connects to an identity that has been historically marginalized (e.g., having a mental illness, being LGBTQ). Additionally, these questions may inadvertently leave someone feeling like they have to “mask” their identity or take the risk of being “outed” (Jones, 2011; Pahwa et al., 2015). Such social dynamics and decisions are important because psychology is a field in which one’s reputation (including their professional identities) plays an important role in their opportunities (Heffernan, 2021; Reinero, 2019). Research also shows that the sharing of similar backgrounds, identities, and experiences has strong influences on the development of a professional relationship (Rivera, 2012). However, if disclosure of SRR on
mental health topics is viewed negatively, then psychologists who do this work may face initial disadvantages at practicing authenticity and being able to form connections.

One concrete example is the recent emphasis on DEI efforts in psychology, where it is increasingly common for graduate applications and job listings in psychology to require that an applicant discuss how they contribute to the diversity of psychology (APA, 2023). Whereas cultivating DEI efforts has often emphasized increasing representation of racial and ethnic, and sexual minoritized groups, the identity of mental illness has received less attention, despite recent calls to de-stigmatize and increase representation of people with mental illness from within academia (Jones et al., 2021; Victor et al., 2022). While this study cannot provide data about how to resolve this dilemma, the present findings about SRR on depression should spark additional discussion about how psychologists can create “a more inclusive, equitable, and diverse field of psychology” that also accepts people with mental illness (APA, 2023).

**Strengths and Limitations**

This study has several strengths and limitations. One notable strength is the sampling procedure. This study systematically extracted over 16,000 email addresses from faculty and graduate students across U.S. doctoral programs in psychology. As a result, this study achieved a relatively large analytic sample of over 1,300 participants to investigate the prevalence and attitudes about SRR. While resource and logistical limitations prevented this study from being able to recruit a truly representative sample, it should be noted that the current sample reflects gender and racial/ethnic characteristics of APA census data (APA, 2022), providing more confidence that these findings apply to the academic field of psychology. This study also improved upon a previously published investigation (Devendorf et al., 2023) by using a counterbalanced experimental vignette design to assess attitudes about SRR. This approach allowed for
specific effects related to the presence or absence of SRR, and the effects of the specific research topic, to be examined. Additionally, the current study used preliminary cognitive interviews to improve upon a previously developed scale to assess stigmatizing, strengths-based, and disclosure attitudes regarding a hypothetical researcher; the factor structure of this scale was generally supported by a CFA. Taken together, this study is the methodologically strongest study of SRR among psychologists to date.

However, the limitations of this study should also be noted. First, building off methods used in our previous work (Victor et al., 2022b; Devendorf et al., 2023), this study aimed to obtain a large sample of U.S. psychologists and trainees. At the same time, the recruitment method (i.e., using publicly available emails) was not able to reach all potential participants, given that some graduate student and faculty emails were not consistently listed on websites. To overcome this obstacle, this study used a forwarding procedure (see Method) in an attempt to reach all potential participants. However, one limitation of this forwarding procedure is that precludes the ability to calculate a true response rate and to guarantee that a participant was a part of the intended sample (e.g., it is possible that a participant came from a non-accredited doctoral program). When calculating the number of emails sent ($N = 16,135$) with the number of useable responses, the approximate, upper-bound response rate for this study was 8.23%. While this response rate was modest, it was consistent with a volunteer survey, and especially in flight of participant survey fatigue following the COVID-19 pandemic (De Koning et al., 2021; Krieger et al., 2023). Finally, the response rate should also be considered in light of recruiting participants from academia, where feelings of overwork and burnout are prevalent (Forrester, 2021; Senthi Kumar et al., 2023; Warlick et al., 2021).
Another limitation of this study is that it was not designed to elucidate why particular attitudinal patterns may have been observed, such as attitudes about SRR depression versus SRR on sexual orientation and SRR on cancer topics. Inspired by previous social psychology research (Kenny et al., 2018), this study attempted to measure general attitudes about each of these identities by using a one-item, face valid assessment. However, the validity of this item is unclear in the current sample, as suggested by a large number of outliers, which may indicate participants were confused with how to respond to the measure. Additionally, it should be emphasized that this study relied on attitudinal assessments of SRR. As a result, the findings cannot be interpreted in terms of how SRRers are behaviorally treated in compared to non-SRRers. Lastly, although this study found evidence of differential attitudes about SRR on depression compared to other identity constructs, this study cannot definitively speak to differences in how SRR on other mental health topics may be perceived.

**Future Directions**

This study is an important step toward understanding and creating awareness about SRR in psychology. The fact that SRR is so common suggests that discussions about SRR will be relevant for years to come. Future research should continue to elaborate on SRR at both a broad (i.e., field-wide) and small (i.e., within person) scale. Some key directions are outlined below.

1. **Understand how contextual factors affect attitudes about SRR.** Attitudes about SRR are likely to vary by context. It would be valuable to understand when SRRers experience advantages and disadvantages, and how observer characteristics (e.g., lay person, academic) affect perceptions of SRR. Additionally, future investigations might examine how SRR is viewed across different career stages, such as during graduate applications, faculty applications, and
grant awards, to clarify the risks and rewards of disclosure. This body of work would create awareness about the barriers, challenges, and potential rewards of conducting SRR.

2: Explore how SRRers can leverage their lived experience. In addition to understanding the perceived benefits and drawbacks of SRR, it would be useful to elucidate the actual experience of researchers who do SRR to learn how their lived experiences are leveraged. Specifically, studies might examine the actual benefits and challenges of conducting SRR, and how this experience varies by context and identity (e.g., having depression). This research could reveal strategies that SRRers could use to engage with their lived experience as an asset while also managing any (potential) ongoing challenges associated with that lived experience. Several commentaries have noted those who have lived experience in relation to a research topic may manage this potential asset (Bogart, 2024; Devendorf, 2021; Jones et al., 2021). These strengths include seeing the problem from a novel perspective, having the ability to form community research partnerships, and having intrinsic motivation that can promote resilience during a long research career.

3: Identify stigma reduction strategies for SRR. Given that this study found evidence of relative stigma toward SRR on depression, future research should examine strategies to reduce stigma toward mental health and SRR. Previous research shows that education (e.g., workshops, lectures, discussions) and contact strategies (e.g., someone sharing their personal narrative about coping with mental illness) are generally effective in the short-term at increasing acceptance of people with mental illness (Brijnath et al., 2016; Corrigan, 2016; Griffiths et al., 2014). However, these interventions are generally not tested in academic samples, let alone samples that include PhD students and psychologists. Ultimately, efforts should seek to create an open
dialogue about how to navigate professional challenges related to perceptions of SRR, while simultaneously reducing SRR and mental health stigma.

Conclusions

This study found that SRR is common across faculty and students who are in psychology doctoral programs in the United States. Across three research topics (i.e., depression, cancer, sexual orientation), hypothetical SRRers were perceived to have advantages of non-SRR, such as being viewed as admirable, serving as good role models, and having insight. However, psychologists and trainees viewed disclosure of SRR (i.e., discussing one’s interest in their research pursuit) as more inappropriate compared to non-SRR. Additionally, psychologists and trainees viewed SRR on depression with more stigmatizing attitudes, and fewer strengths-based attitudes, compared to SRR on cancer and SRR on sexual orientation. These findings suggest that psychology must pursue efforts to promote acceptance of SRR, regardless of research topic. At the same time, this study’s implications are not suggesting that SRR is superior to non-SRR; rather, promoting a more engaged dialogue about SRR can help promote transparency of researcher’s perspectives, intentions, and motivations, whereas continuing a culture of silence is likely to have these issues and challenges go unaddressed. Through promoting awareness and acceptance of SRR, psychology will be in a stronger position to support its own in this field.
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APPENDIX A: THE STIGMA, STRENGTHS, AND DISCLOSURE (SSD) SCALE

Please answer each of the following questions about Sam. Choose the answer that you feel most honestly about when considering Sam's background.

**Answer options:** Disagree strongly (1), Disagree (2), Neither agree nor disagree (3), Agree (4), Agree strongly (5)

**Stigmatizing Attitudes Subscale**
1. Sam will be biased in their research on this topic.
2. Sam’s research pursuit is irresponsible.
3. Sam should pursue a different research topic.
4. Sam’s research pursuit is selfish.
5. Sam has bad judgment for pursuing this research topic.
6. Sam’s research is not trustworthy.
7. Sam is pushing an agenda with their research.
8. Sam is doing research for the wrong reasons.

**Strengths-based Attitudes Subscale**
1. Sam is admirable for researching this topic.
2. Sam has motivation to research this topic.
3. Sam has insight into this research topic.
4. Sam serves as a good role model in the academic community for their research pursuit.
5. Sam should be accepted by the academic community for their research pursuit.
6. Sam’s research pursuit is meaningful.
7. Sam’s research pursuit is respectable.
8. Sam’s background gives them a unique perspective.

Below are some situations where Sam might talk about their personal relationship to their research area.

Given Sam's background – how they became interested in this topic – how appropriate do YOU think it is for Sam to disclose their personal interest in their research topic in the following situations?

**Answer options:** Very inappropriate (1), Inappropriate (2), Neither appropriate nor inappropriate (3), Appropriate (4), Very appropriate (5)
Disclosure Views Subscale

A. Disclose publicly, such as when writing an essay for a magazine, blog, or talking with a journalist.
B. Disclose when giving a talk at a research conference.
C. Disclose to anyone in the academic community.
D. Disclose during a campus interview.
E. Disclose in a personal statement.
F. Disclose in a diversity statement.
G. Disclose on social media, like Twitter or Facebook.
H. Disclose while teaching a class.
I. Disclose to an academic mentor.
J. Disclose in a positionality statement.
APPENDIX B: SELF-RELEVANT RESEARCH (SRR) IDENTITY QUESTIONS

The following questions ask about your experiences with self-relevant research.

As a reminder, *self-relevant research* ("me-search") is research by someone with a lived experience with, or a close connection to, their research area. A close connection could be, for example, a family member or a close friend who has lived experience with their research area.

**SRRexp.** Have you ever conducted self-relevant research ("me-search")? This could be related to any aspect of your identity, experiences, or those of the people close to you.

Here are just some examples of self-relevant research:
- A person who has experienced depression doing research on depression
- A person whose parent experienced schizophrenia doing research on schizophrenia
- A Black person doing research on the unique experiences of Black people
- A person whose spouse died of cancer doing research on cancer or grief
- A lesbian person doing research on lesbian mental health

- Yes, I currently conduct this type of research (1)
- Yes, not currently but in the past (2)
- No (0)
- Prefer not to answer (-89)

**DISPLAY THE FOLLOWING IF PRIOR QUESTION ANSWERED 1 OR 2**

**SRRaff.** In what way(s) does your research intersect with your experiences? Select all that apply.
- Lived experience with your research topic (e.g., lived experience with racism, as an LGBGTQ+ person, you have/had a mental illness, other lived experiences) (1)
- Close connection to someone else whose lived experiences relate to your research topic (e.g., a family member lives with chronic illness, a romantic partner experiences transphobia, other close connections) (2)
- Other (3) _________________
- Prefer not to answer (-89)
SRwhen. When did your personal connection(s) to your work occur? Select all that apply.

- I had a personal connection to my field of study before I chose it/started to work in that field (1)
- I chose my area of research and developed a personal connection to it later (2)
- Other (3) ________________________________________________
- Prefer not to answer (-89)

DISPLAY IF PRIOR QUESTION (SRRaff) OPTION 1 SELECTED

SRlived. Please select how your research intersects with YOUR lived experiences. Remember, a lived experience refers to an experience or identity that YOU have experienced, and it connects to your research. Select all that apply.

- Your mental health difficulties or mental illness are related to your research.
- Your physical health difficulties or physical illness are related to your research.
- Your racial or ethnic identity/identities is/are related to your research.
- Your sex or gender identity is/are related to your research.
- Your sexual orientation or sexual identity is related to your research.
- Your disability/disabilities is/are related to your research.
- Your neurodivergence is related to your research.
- Your experience as a military member or veteran is related to your research.
- Your experience with parenting or caregiving is related to your research.
- Your religious or spiritual identity/identities is/are related to your research.
- Other: ____________________________
- Prefer not to answer (-89)
SRconn. Please select how your research intersects with a CLOSE CONNECTION to someone or some area in your life. Remember, a close connection could be, for example, a family member or a close friend who has lived experience with your research topic. Select all that apply.

- The mental health difficulties or mental illness of someone you are close to is/are related to your research.
- The physical health difficulties or physical illness of someone you are close to is/are related to your research.
- The racial or ethnic identity/identities of someone you are close to is/are related to your research.
- The sex or gender identity of someone you are close to is/are related to your research.
- The sexual orientation or sexual identity of someone you are close to is related to your research.
- The disability/disabilities of someone you are close to is/are related to your research.
- The neurodivergence of someone you are close to is related to your research.
- The experience as a military member or veteran of someone you are close to is related to your research.
- The experience with parenting or caregiving of someone you are close to is related to your research.
- The religious or spiritual identity/identities of someone you are close to is/are related to your research.
- Other
- Prefer not to answer (-89)