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A Qualitative Study Of Experiences Of Counseling Graduate Students With Chronic Mental Illness

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A QUALITATIVE STUDY OF EXPERIENCES OF COUNSELING GRADUATE STUDENTS WITH CHRONIC MENTAL ILLNESS

A Dissertation

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In Partial Fulfillment

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Doctor of Philosophy in Counselor Education and Supervision

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by

Mary Kathleen Curry

August 2024

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Approved August 2024 by

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Jesse Fox, Ph.D.

Dedication

To the teachers and professors who believed I had more in me than the anger or indifference I showed up with.

And to the high school students who made me into a teacher.

Acknowledgments

First, to the students who shared their lives and experiences with me for this research. It was brave and I am glad you are all in this field. Counseling is better with you in it, and I hope that we can keep building counselor education to be a place where neurodiversity is welcomed. The differences make us stronger, better, and kinder clinicians and colleagues.

I'd like to take this opportunity to thank my chair and advisor, Dr. Craig Cashwell. The stalwart recipient of far too many (largely) unanswerable e-mails; the holder of many big feelings; and most patient of sounding boards who has shown me again and again it is possible to be in higher ed and keep students as a priority. That modeling has kept me tethered when anger, frustration, and despair have reared their heads. I recognize that few would describe me as an "easy person to be around," and still you allowed me the space to grow, gifting me both challenge and support. I count myself quite lucky to have had you as a teacher, advisor, and chair. I'm in your corner, too.

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To my mom, who has had to read far too many drafts of papers over the years; listened to far too many calls on drives to and from Williamsburg; and offered invaluable perspectives again and again. To my dad, who has always been confident that I am smart enough to do just about anything, even when I do very dumb things.

To my Leches, who have loved and carried me through every season.

Last here, but first in my mind, always – to my family, I am a better human being because of you. I love you four tremendously.

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Abstract

This dissertation explored the lived experiences of counseling graduate students living with a diagnosis of a chronic mental illness. Despite the prevalence of mental illness among graduate students, limited research has explored their unique experiences, particularly within counselor education. This study employed Interpretive Phenomenological Analysis as an approach to explore this lived experience. By focusing on their personal narratives, this research shed light on the strengths and challenges of these students while navigating their academic and professional journeys. Central to this investigation was Bandura's self-efficacy theory, which provided a lens through which to understand how these students perceive their ability to succeed. Data from 8 participants was collected through in-depth interviews, which evoked rich, detailed accounts of their experiences. The study contributes to the existing literature by offering a nuanced understanding of the intersection between chronic mental illness and counselor education, potentially informing inclusive practices in the field. While the overarching research question was about the lived experiences of counseling graduate students living with a diagnosis of chronic mental illness, semi-structured interview questions were developed to explore students' experiences of stigma, support systems, and the impact of their diagnosis on their self-efficacy beliefs. The findings revealed a complex interplay of factors that shape and shaped these students' experiences, including faculty support, stigma, self-stigma, and viewing their CMI as a clinical strength.

Index Words: chronic mental illness, counseling graduate students, stigma, help-seeking, gatekeeping

A QUALITATIVE STUDY OF EXPERIENCES OF COUNSELING GRADUATE STUDENTS WITH CHRONIC MENTAL ILLNESS

Chapter One: Introduction

Background

Mental illness refers to a range of psychiatric conditions that affect a person's mood, thoughts, behavior, and overall functioning (American Psychological Association, 2017). Mental illness occurs on a spectrum, with conditions ranging from transitory to chronic, and the distinction between the two can sometimes be difficult to make (Ringland et al., 2019). Chronic mental illness refers to a mental health condition that persists over an extended period, often for a person's entire life. Examples of chronic mental illnesses include schizophrenia, bipolar disorder, generalized anxiety disorder, and major depressive disorder (Ringland et al., 2019). More transitory mental illnesses, on the other hand, may be temporary or occur in response to specific life stressors or traumatic events. Examples of transitory mental illnesses include adjustment disorders, post-traumatic stress disorder (PTSD), and acute stress reactions (Ringland et al., 2019). These conditions can occur in response to changes in life circumstances, such as the loss of a loved one or a major life transition (American Psychological Association, 2017).

The presence of mental illness among helping professionals is not a novel idea. The concept of the *wounded healer* in the counseling and mental health fields is a long-standing idea that has evolved over time (Rice, 2010). The basic premise is that individuals who have personally experienced trauma, mental illness, or other life challenges have a unique perspective and can offer insight and empathy to others facing similar struggles. This concept is based on the idea that people who have experienced pain and suffering can be transformed by that experience and can use that knowledge to help others. The wounded healer can be traced back to ancient Greek mythology, where the myth of Asclepius, the god of healing, was said to have acquired his knowledge and skill through suffering (Jung, 1969). In the 20th century, psychologist Carl Jung popularized the idea in his work, incorporating it into his theories on the psychology of the self and the importance of personal growth and transformation (Jung, 1969). This has appeared to become almost a prerequisite for many in the helping field, as illustrated by Heimann (1968) who wrote that "…what we really expect in a psychoanalytic candidate is that he should have a good heart and that he (sic) should have gone through some suffering without denying it.'

To date, however, there has been limited empirical attention to this concept. Hinshaw (2008) explored the personal experiences of mental health professionals with mental illness and found that many professionals felt that their experiences helped them to better understand and empathize with clients facing similar challenges, though relied on anecdotal retelling. The authors suggested that the wounded healer model can be a valuable approach for promoting self-reflection and growth in the helping professions, as well as for reducing stigma and promoting understanding and acceptance of mental illness. Kosyluk et al., (2021) found that students who have personal experience with mental illness may be more likely to seek help and support when they need it. This familiarity with mental illness can lead to decreased stigma, and translate into empathetic care for clients with more stigmatized diagnoses.

It also bears mentioning, however, that untreated or unmanaged woundedness may lead to impairment in a counselor's ability to practice competently. Mental illness can potentially impair a counselor's work in a number of ways, depending on the management and severity of the illness. An example from the literature is that a counselor who is experiencing symptoms of depression may struggle with maintaining a positive attitude, engaging with clients, or providing empathetic support (Gilroy et al., 2002). Similarly, a counselor who is experiencing symptoms of anxiety may struggle with maintaining focus, managing stress, or addressing difficult topics with clients (Shamoon et al., 2017).

While there may be cases where a counselor's mental illness negatively impacts their ability to provide services, it is important to recognize that this is not a common occurrence. In fact, many counselors who experience mental health challenges are able to continue providing effective services with appropriate treatment and support (Ponew et al., 2023) . Additionally, many counseling organizations offer resources and support to counselors who are experiencing mental health challenges in order to ensure that they are able to provide competent and ethical services (American Counseling Association, 2014).

There does not seem to be data on a specific type of "wound" that results in CMI. Mental illness is a complex phenomenon that can be influenced by a variety of biological, psychological, and social factors. While a trauma-informed lens suggest that trauma may underlie many experiences of mental illness (Zarse et al., 2019), the exact causes of mental illness are still not fully understood and likely vary from person to person. There is research, however, on the causes and risk factors of chronic mental illness, including the role of traumatic experiences and adverse life events in its development. Some researchers, such as Felitti et al., (1998), have found that traumatic experiences, such as childhood abuse or neglect, can increase the risk of developing chronic mental illness later in life. Other researchers, such as Sullivan et al., (2000) and Kendler et al., (2004), have explored the role of genetics, brain chemistry, and environmental factors, such as poverty or lack of social support, in the development of chronic mental illness.

Despite the overall positivity of many definitions of the *wounded healer,* in the general population the issue of stigma surrounding chronic mental illness and the decision to self-disclose one's mental health status has been the subject of much research and discussion. Many studies demonstrate that people labelled as mentally ill often are stigmatized and discriminated against due to societal attitudes and beliefs about mental illness (Corrigan & Watson, 2002;

Martin et al., 2000; Parcesepe & Cabassa, 2013). This stigma has been shown to have a significant impact on individuals with chronic mental illness, leading to decreased self-esteem, reduced access to treatment and support, and increased feelings of isolation and shame (da Silva et al., 2020). Stigma and bias towards individuals with chronic mental illness is a pervasive problem and has been the focus of numerous studies in the mental health field. Thornicroft (2006) found that individuals with chronic mental illness often face significant stigma and discrimination in various areas of life, including employment, housing, and healthcare. This stigma can act as a barrier to help-seeking, as individuals may be reluctant to seek treatment due to shame and embarrassment. The author argued that anti-stigma campaigns and initiatives are crucial for reducing the stigma associated with chronic mental illness and promoting understanding and acceptance.

The same appears true for student populations. For example, Muscari et al. (2012) found that students with chronic mental illness often face stigma and discrimination from both their peers and educators, leading to feelings of shame and decreased self-esteem. Further, this stigma can limit access to support services and impact their overall well-being. Similiarly, Biegel et al. (2009) found that students with chronic mental illness are at increased risk of academic difficulties and are less likely to complete their education compared to their peers without mental illness. Biegel et al. also found that students with chronic mental illness often experience high levels of stress and anxiety, which can impact their ability to succeed academically.

Helping and medical professionals do not appear to be above the fray when it comes to stigma and discrimination. Researchers have shown that disclosure of mental illness by helping professionals, such as doctors, therapists, social workers, and psychologists, can result in negative professional impacts (Hankir et al., 2014). For example, Zamir et al., (2022) found that mental health professionals who disclosed their mental health struggles experienced stigma, including decreased trust from clients and professional colleagues, and negative consequences for their career.

There remains some stigma involved around this within the counselor education world, and admissions committees remain wary of too much disclosure of woundedness in applications and interviews (Salzer, 2022). Disclosure around woundedness can transgress the professional disposition regarding boundaries and can set off warning bells in evaluative faculty or admissions committees. (Zöld et al., 2021) found that *despite* evaluating a hypothetical student as a good programmatic fit and likely to succeed professionally, counseling faculty were far less likely to admit a candidate who disclosed depression and psychotherapy in their personal statement. The field of counseling has not yet progressed to the stage of developing a consistent way to address being a wounded healer, distinguishing that from impairment, and what that means for counseling practice (Streeter, 2017)

There is a pressing need to develop a professional response to a growing proportion of students who have specific legal rights, as well as to look towards current best practices around gatekeeping. There is also a significant purpose in developing a stronger base of understanding some of these experiences to best support counseling students, and to be able to examine best practices in education. Beginning to develop data around this population within programs may serve a crucial component in terms of supporting faculty while also protecting students.

Further, the historical context of mental illness and diagnosis in the US is tightly bound up with stigma and misinformation that intersects across racial, ethnic, gender, sexual orientation, class, and religious lines, with varying levels of stigma and self-stigma placed within larger identity and social constellations (Wong et al., 2017). Historically, marginalized persons have been over diagnosed with chronic mental illness (Mongelli et al., 2020). Qualities perceived as desirable in some individuals have been viewed as negative or perhaps even pathological in marginalized folx (i.e. a white person being seen as ‘assertive’ while a Black person exhibiting similar behaviors is viewed as ‘aggressive’ or ‘anti-social’).

The same seems to occur for counseling students as researchers have found that Black counseling students experience various forms of racism and discrimination in their education and professional training. For example, (Basma et al., 2021) found that Black counseling students faced racial microaggressions, such as being subjected to negative racial stereotypes, being ignored in class, and being tokenized. The authors also noted that these microaggressions can have a significant impact on the mental health and well-being of Black students, leading to feelings of isolation and devaluation. Similarly, (Haskins et al., 2013) investigated the experiences of Black graduate students in counseling programs and found that they faced challenges related to cultural competence, including the emotional labor of having to educate their White professors and peers about racism and diversity, and dealing with resistance and denial from the White counseling community. (Henfield et al., 2013) found that many Black counseling students experienced racism and cultural insensitivity in their counseling programs, which impacted their ability to disclose personal information. They concluded that a lack of cultural competence among faculty and peers, as well as a lack of understanding of the experiences of Black individuals, can contribute to a negative disclosure experience for Black counseling students ostensibly including disclosure of a CMI, though to date this has not been examined empirically.

Researchers have, however, begun to examine the impact of mental illness overall on graduate students. For example, (Becker et al., 2002) found that graduate students with chronic mental illness are likely to experience a range of negative impacts, including decreased academic performance and well-being. These authors argued the importance of addressing stigma and bias in the helping professions, where individuals with chronic mental illness may be disproportionately represented. The authors suggested that creating supportive and inclusive environments, including providing resources and accommodations, is essential for promoting the success and well-being of graduate students with chronic mental illness.

A large portion of gatekeeping processes and examining professional dispositions of students measures the student's ability to work successfully with clients. There is some murkiness surrounding how a program or evaluator might do so. The American Counseling Association (2014) outlines nine dispositions that it considers essential for the effective practice of counseling. These dispositions are: (1) Empathy, (2) Social Justice Advocacy, (3) Cultural Responsiveness, (4) Self-Awareness, (5) Clinical Inquiry and Evidence-Based Practice, (6) Professional Identity, (7) Personal It Growth and Professional Development, (8) Ethical and Legal Practice, and (9) Collaboration and Community Engagement. The CACREP 2016 Standards include a list of Core Professional Identity Standards and Core Clinical Mental Health Counseling Standards that address many of the same areas (though without specific definitions and objectives), and requires that programs seeking accreditation identify core dispositions and demonstrate measurement and analysis of those dispositions when evaluating student performance (CACREP, 2016).

There has been some debate and critique around the CACREP core dispositions. One issue is that some scholars have argued that the core dispositions lack clarity and specificity, which makes it difficult for counselor educators and supervisors to assess and develop these dispositions in their students (Rust et al., 2013). There is some variation in how accredited counseling programs use and interpret counseling dispositions, such as those outlined in the CACREP Standards or the ACA Code of Ethics.

Some programs have integrated the dispositions into their curriculum and assessment processes in a systematic and intentional way, using the dispositions to guide course content, and through the utilization of rubrics, scales, and other assessments (Lambie & Haugen, 2022). Other programs may not prioritize the dispositions to the same extent or may interpret them differently based on their program goals and philosophy (Lopez & Gertz, 2016). For example, researchers have found that some programs emphasized the importance of cultural competence and social justice advocacy as key dispositions, while others focused more on clinical skills and professional identity (Wilkerson, Bellini, & Paterson, 2016).

Another issue is that the core dispositions may not fully capture the diverse range of knowledge, skills, and attitudes that are necessary for effective counseling practice. For example, some scholars have argued that the core dispositions do not adequately address the importance of social justice and advocacy in counseling practice, particularly in the context of systemic oppression and marginalization (Holcomb-McCoy, 2016; Lewis et al. 2002). Additionally, some have raised concerns about the potential for the core dispositions to perpetuate dominant cultural norms and values, rather than promoting cultural humility and responsiveness (McCarthy & Van Hoose, 2017).

In a proposed addendum to the dispositions, (Redekop & Wlazelek, 2010)stated that “When considering counselor dispositions, we believe there is a sense that counselor educators ‘know them when they see them.’ Counselors and promising counseling candidates are warm rather than cold, flexible rather than rigid, interested rather than uninterested, kind rather than mean, supportive rather than unsupportive, empathic rather than unempathic” (p. 2). While this list on its face sounds appropriate enough and acceptable, it also demands a large level of racial identity awareness, multicultural proficiency, and vigilance for bias and subjectivity from the evaluators. In the same article, the authors admitted a limitation in that these norms might be narrowed to dominant cultural norms that do not speak to multicultural or marginalized experiences. It seems possible, then, that biases against students may be exacerbated for students of color or otherwise marginalized individuals.

Statement of the Problem

Many mental health professionals, including counselors, find themselves drawn to the counseling field due to their own experience with being wounded (Jung, 1969; Nouwen, 1990). Within counselor education, the concept of the *wounded healer* is a common idea with most persons entering the field having some personal experience of woundedness (Streeter, 2017) While there is a body of work examining the role of structural processes concerning professional dispositions and varied programmatic responses when ongoing woundedness reflects as impairment (Foster & McAdams, 2009; Goodrich & Shin, 2013; Letourneau, 2016), what remains largely ill-defined from a programmatic view is when that woundedness is part of a diagnosed mental health concern. Zöld et al. (2021) found that *despite* evaluating a hypothetical student as a good programmatic fit and likely to succeed professionally, counseling faculty were far less likely to admit a candidate who disclosed depression and psychotherapy in their personal statement. The field of counseling has not yet progressed to the stage of developing a consistent way to address being a wounded healer and what that means for counseling practice (Streeter, 2017). Without clarity about delineating a wounded healer from one who is impaired in some way, the potential for bias and discrimination remains problematic.

Scholars have highlighted this importance of examining bias and discrimination for students with a mental illness. For example, Willyard, (2012) found in a poll at Berkeley that 45 percent of graduate students said they had a mental health issue that affected their well-being or academic performance, and almost 10 percent of respondents reported they had considered suicide in the past year. It seems, then, that students with chronic mental illness are enrolled in counseling programs in substantive numbers; increasingly, some are rightfully asking for ADA accommodations, and counseling faculty are placed in a unique position as educators who are trained to respond to mental illness in particular ways, as well as operate as professional gatekeepers.

Some counselor educators argue (Johnston et al., 2005; Rance et al., 2010) that some students with mental illness are at risk of becoming impaired/incompetent professionals because of the impact of their illness, whereas medical professionals have noted that having a mental illness does not necessarily mean that the student is either unfit to practice or impaired (General Medical Council, 2020). Therein lies a professional tension that has not yet been adequately examined.

Through the history of counselor education, there have been responses to counselors in training with mental illness that have ranged from accommodating with high levels of support to termination for professional impairment (Rance et al., 2010). Unfortunately, though, there do not appear to be clear policies or guidelines that inform best practices for working effectively with students with chronic mental illness to balance their rights with the gatekeeping function of faculty and supervisors (ACA Code of Ethics, 2014, Standard F.6.b). It seems likely that such a lack of policy or best practices leaves vulnerable students in a precarious position of deciding whether to disclose their mental illness and counseling faculty in a challenging place of balancing the rights of students while maintaining their role as gatekeepers to protect future clients from an impaired professional. There seems a need, then, for more clear guidance on best practices for working with counseling students diagnosed with a chronic mental illness, a process that can be informed by better understanding the lived experience of counseling students with CMI.

Purpose Statement

The purpose of this study is to anchor a starting point for exploring how counselor education is responding to the mental health experiences of counseling students. While students with chronic mental illness have always been present in graduate programs and the helping professions, non-anecdotal data are sparse. More specifically, this study opens the door to start understanding the lived experience of counseling students with chronic mental illness (CMI).

Researchers have shown that mental health professionals, including psychiatrists, psychologists, and social workers, have higher rates of mental health diagnoses compared to the general population. A study published in the Journal of the American Medical Association in 2011 found that the prevalence of depression among psychiatrists was 12.3%, which is higher than the general population (7%). A study published in the Journal of Clinical Psychology in 2019 found that rates of burnout among psychologists can range from 30% to 60% (Evans et al., 2018). Scholars also have found that social workers are up to four times as likely for developing symptoms of depression compared to the general population (Alaggia et al., 2023). In looking at rates of diagnoses in similar helping professions (psychiatry, psychology, and social work), it is not an unreasonable step to infer that there are similar rates within the counseling field, although this has not been empirically examined to date.

Accordingly, this project seeks to add to the knowledge around the experiences of master's level counseling students who have been diagnosed with a mental illness. Such knowledge will deepen our understanding of student experiences and the intersection of students with CMI and existing professional gatekeeping tasks and definitions regarding impairment and problematic behaviors among students.

Significance of the Study

This study potentially adds to the knowledge base for counseling students, counselor educators, and supervisors in terms of both strengths and needs of students living with a diagnosis of a CMI. Further, by extension, students who are better served by educators, supervisors, and educational support systems may better serve future clients. As the demographics of counseling students shift and as some of the stigma around mental health lessens, counseling faculty are likely going to experience more students who openly present with CMI who will be legally entitled to ADA protections and will also bring their unique lived experiences and strengths to the classroom and field. To date, however, researchers have not sought to systematically understand the experiences and needs of counseling students with CMI.

Research Questions

The following research questions have been developed around a phenomenological qualitative structure, informed by the theoretical framework of Bandura's self-efficacy work. This study seeks to develop an understanding of the experiences of counseling students and CMI.

1. What is the lived experience of counseling students who live with a CMI?

From this, two sub-questions of interest will also be considered:

A. What kind of role does/did stigma or self-stigma play in your experience?

B. What has been/was the experience of disclosure or non-disclosure of CMI within a counseling program and why?

By addressing these questions, the study seeks to illuminate the unique challenges that graduate counseling students with CMI face and provide valuable insights that can guide the development of supportive interventions (American Counseling Association, 2014). In doing so, it contributes to filling a critical gap in the existing literature on self-efficacy in the context of mental health and graduate counseling training (Joyce et al., 2015).

Theoretical Framework

Self-efficacy, a cornerstone concept in Bandura's social cognitive theory (1977), refers to an individual's perceived ability to perform given actions to achieve desired outcomes. It has found wide application in various domains, including counseling and mental health; influencing how researchers understand how individuals manage challenges, cope with adversity, and recover from failure (Bandura, 1997). In the realm of counseling, self-efficacy plays a pivotal role in shaping the therapeutic process. Therapists with higher self-efficacy are reported to exhibit resilience in the face of setbacks; approach challenging situations more confidently; and demonstrate persistence until therapeutic goals are achieved (Larson & Daniels, 1998; Lent et al., 2006).

Bandura's self-efficacy model underscores key personal and environmental factors that shape these perceptions. Personal factors incorporate one's performance accomplishments, vicarious experiences, emotional states, and verbal persuasion. Environmental factors embody the structural and sociocultural contexts that individuals navigate (Bandura, 1997; Usher & Pajares, 2008). This model has particular relevance for understanding the experiences of graduate counseling students with CMI (Joyce et al., 2015) . These students might grapple with additional complexities due to the intersection of their academic pursuits, the demands of their clinical training, and the management of their mental health (Eisenberg et al., 2007).

Limitations

While an interpretive phenomenological approach provides deep insights into the lived experiences of graduate counseling students with chronic mental illness (CMI), it comes with certain limitations. One of the primary limitations is that the experiences documented in this study are inherently tied to the specific phenomenon being experienced at the time by the participants. Consequently, these findings may not be generalizable to all counseling students with CMI (Hays & Singh, 2012). Additionally, the inherently subjective nature of qualitative research poses challenges in replicating the study and obtaining identical results. To mitigate this limitation, I employed bracketing techniques and engaged an auditor to review the data. This helped ensure consistency of themes and enhanced the study's dependability. Nonetheless, the unique and contextualized nature of the participants' experiences should be considered when interpreting the study's findings.

Another significant limitation is the potential for researcher bias, which can influence data collection and interpretation (Creswell, 2013). Although steps such as bracketing and the use of an external auditor were implemented to address this issue, it is impossible to eliminate all personal biases. This could affect the credibility of the findings (Morrow, 2005). Furthermore, the reliance on self-reported data may introduce issues related to the accuracy and honesty of the participants' accounts (Patton, 2015). Memory recall bias or the desire to present themselves in a certain light can lead to inconsistencies or exaggerations in the data (Shenton, 2004). Despite these precautions, the intrinsic depth and richness of qualitative data remain valuable for its potential to reveal novel insights into the lived experiences of counseling students with CMI (Smith & Osborn, 2007).

Delimitations

My goal was to purposely select 8-12 counseling graduate students with CMI from CACREP accredited programs to serve as participants. This allowed me to collect extensive detail about each participant to and to achieve saturation. I provided extensive information about the purpose of the study to the participants and require verbal and signed consent from all participants. Bracketing was employed throughout the study to ensure the absence of my judgment and to ensure my ability to analyze the data with a fresh perspective (Creswell & Poth, 2017; Haskins et al., 2021).

Definition of Terms

Wounded Healer. The wounded healer is defined as an individual who: (a) has suffered or is suffering physical and/or emotional trauma or distress from which they have worked or are working to heal (i.e. recover or manage); and, (b) consequently, has gone on to heal others as a counselor (Bryant, 2006; Foreman, 2005; Schneider & May, 2012). Wounded healers are driven by the desire to relieve the suffering of others after experiencing or witnessing suffering in their own lives (Christie & Jones, 2014).

Stigma. For the purposes of this study, stigma is defined as the negative evaluation made by an individual towards an observable characteristic that deviates from societal norms (Corrigan & Watson, 2002; Hinshaw, 2008). Stigmatization is driven by the larger social contexts, including organizations, institutions, and culture (Goffman, 1986). Perceived or self-stigma captures the stigmatized views individuals believe other people may hold regarding mental illness (Corrigan & Rao, 2012).

Gatekeeping. Gatekeeping refers to the responsibility of all counselors, including student counselors, to intervene with colleagues and supervisors who engage in behavior that could threaten the welfare of those receiving services (Foster & McAdams, 2009). The American Counseling Association (ACA) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) both outline the necessity of gatekeeping and professional dispositions, in line with ethical codes for both, though largely leave the construction of procedures to the individual programs (ACA Code of Ethics, 1014).

Self-Disclosure of CMI. Self-disclosure of mental health issues is extremely complicated and fraught with vulnerabilities. When people who bear a concealable stigmatized identity or trait that is socially devalued but is not readily apparent to others, such as mental illness, disclose this information to others, they risk experiencing negative outcomes or even becoming the targets of prejudice identity (Pachankis, 2007; Quinn & Chaudoir, 2009). In these cases, decisions to disclose concealable stigmatized identities are much more complex because they may yield unfavorable outcomes such as social rejection and discrimination.

Impairment. While displayed harm to patient or client and certain negatively perceived interpersonal and professional behaviors have been historically understood under an umbrella term of *impairment*, Capps (2008) reported little agreement about what constitutes impairment, and thus no actual concrete definition of impairment exists. This has most likely contributed to a wide amount of disparity regarding how individual programs respond to counseling students who are identified as impaired, or in more modern parlance, *problematic*.

The replacement of the term *impairment* with *problematic* is very intentional, as (Brear et al., 2008; Elman & Forrest, 2008) have suggested that terms such as “impaired” or “incompetent” not be used due to their overlap with legal terms used by the Americans with Disabilities Act (ADA). The ADA provides protection against discrimination for individuals with mental health diagnoses. According to the Equal Employment Opportunity Commission (EEOC), "The ADA defines an individual with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment" (EEOC, 2021).

Balancing the protection of individuals with mental health diagnoses under the ADA with the welfare of counseling clients present and future can be a complex issue. On one hand, the ADA prohibits discrimination against individuals with mental health diagnoses in areas such as employment and education. On the other hand, counseling involves providing a safe and ethical environment for clients, and in some cases, the behavior of an individual with a mental health diagnosis may pose a threat to the well-being of clients

Chronic Mental Illness. A person’s experience of mental illness can be overall a period of several weeks to learning to co-exist with that diagnosis for the rest of their life. When patterns of relapse become apparent without maintenance and management, mental illnesses may fall under the category of chronic mental illness (Prasad, 2017). The most common diagnoses housed under the term *chronic mental illness* tend to be in the mood disorder categories, including both depression and anxiety.

Summary

This chapter has laid the groundwork for introducing the topic of this proposed study and grounded it in historical and contemporary contexts. The significance and need for this study were provided, theoretical framework introduced, and the main terms of the study described. In Chapter 2, a thorough review and analysis of existing literature will be completed. In Chapter 3, I will describe the methodology used to understand this phenomenon in greater depth. Chapters 4 and 5 will describe the findings of the study and provide a discussion of those findings, respectively.

Chapter 2: Review of Literature

Overview

With the established need for an increased professional understanding of the role CMI plays in graduate counseling students' experiences, it is necessary to review the research around this proposed study's major terms and topics. The first section of this chapter will provide an examination of relevant literature around the various contexts and applications of this topic, while making connections to the proposed research study. The second section will provide summarization and synthesis of the literature as it relates to the proposed framework. Upon reviewing the literature, a gap emerges that creates a need for focused study.

Chronic Mental Illness

Chronic mental illness (CMI) in the United States is a significant public health concern, affecting millions of individuals, their families, and society at large (NIMH, 2020). CMIs are long-term conditions that persist over time, often requiring ongoing treatment and management. Examples of chronic mental illnesses include schizophrenia, bipolar disorder, major depressive disorder, and anxiety disorders (National Institute of Mental Health, 2021).

The prevalence of CMI in the United States is substantial. According to the National Survey on Drug Use and Health (2020), approximately 21.8% of adults experienced mental illness in the past year, with 5.2% experiencing serious mental illness. Further, the impact of chronic mental illness extends beyond the affected individuals, also affecting families, communities, and the economy. Chronic mental illness can lead to reduced quality of life, impaired daily functioning, increased healthcare costs, and lost productivity (Hyde & Enomoto, 2015; Insel, 2008).

CMI researchers have focused on various aspects, including the biological underpinnings of these conditions, effective treatments, and strategies for improving access to care and reducing stigma. Recently, researchers have expanded the field's understanding of the genetic and neurobiological factors associated with chronic mental illness (Gandal et al., 2018; Smeland et al., 2020). Additionally, advances in psychopharmacology and psychotherapy have led to the development of more effective treatments for various chronic mental illnesses (DeRubeis et al., 2005; Lieberman et al., 2005).

Despite these advances, significant gaps remain in the research on chronic mental illness. One critical gap is the limited understanding of the long-term trajectories of these conditions and the factors that influence recovery or relapse (Insel, 2009). Another gap is the lack of research on the experiences of underrepresented populations, such as racial and ethnic minorities, who may face unique challenges related to chronic mental illness (Marrast et al., 2016).

Often, individuals with chronic mental illness face several challenges in accessing care and achieving positive outcomes. These challenges include inadequate insurance coverage, a shortage of mental health professionals, and stigma associated with mental illness (Fox et al., 2018). Potential interventions to address these challenges include expanding insurance coverage for mental health services, increasing the mental health workforce, and implementing anti-stigma campaigns (Evans et al., 2018; Mechanic, 2012).

Chronic mental illness in the United States is a prevalent and impactful issue with significant implications for individuals, families, and society. While substantial progress has been made in understanding and treating chronic mental illness, gaps remain in the research, and affected individuals continue to face challenges in accessing care and achieving optimal outcomes. Future researchers should focus on understanding the long-term trajectories of chronic mental illnesses, identifying factors that promote recovery and prevent relapse, and examining the unique experiences and needs of underrepresented populations. Further, there is extremely scant research on the impacts of chronic mental illness among mental health helping professionals and the experiences of students with chronic mental illness in higher education.

Gen Z and CMI

In addition to overall increases in mental illness in the general population, recent researchers have shown that mental health issues among Gen Z individuals (those born between 1997-2012) are a growing concern. This is important because Gen Zers are now increasingly beginning graduate studies, the focal point of this study. According to the American Psychological Association (2019), 27% of Gen Zers say that their mental health is fair or poor, as opposed to 15% of millennials (born between 1981 and 1996) and 13% of Gen Xers (born between 1965 and 1980). In a nationally representative survey of 1,523 responses including an oversample of Gen Z respondents (aged 16 to 24, n = 874), Gen Z respondents were more likely to report having been diagnosed with a behavioral-health condition (for example, mental or substance use disorder) than either Gen Xers or baby boomers (McKinsey Consumer Behavioral Health Survey, 2020). While this finding may be, at least in part, a function of decreased stigma around mental illness and increases in psychological help-seeking among Gen Z, Gen Z respondents also were two to three times more likely than other generations to report thinking about, planning, or attempting suicide in the 12-month period spanning late 2019 to late 2020.

Based on recent research in the field, several factors appear to contribute to the high prevalence of mental health issues among the Gen Z population. These factors can be broadly categorized into four main themes: socio-cultural factors, technological influences, academic pressure, and family dynamics.

1. Socio-cultural Factors: Researchers suggest that Gen Z is more likely to experience stress and anxiety due to societal expectations, economic pressures, and political uncertainties (Twenge et al., 2018)Additionally, increased awareness of mental health issues may lead to higher rates of self-reporting and diagnosis (Orben & Przybylski, 2019).
2. Technological Influences: The rise of social media and constant connectivity have been linked to increased feelings of loneliness, depression, and anxiety among Gen Z (Viner et al., 2019). Excessive screen time and exposure to cyberbullying also are significant contributors to mental health issues in this demographic (Madigan et al., 2019).
3. Academic Pressure: The competitive nature of modern education systems and the pressure to succeed academically have been shown to increase stress levels and negatively impact the mental health of Gen Z individuals (Curran & Hill, 2019).
4. Family Dynamics: Family-related stressors, such as parental expectations and family conflict, also can contribute to the high prevalence of mental health issues among Gen Z (Herrenkohl et al., 2009).

In terms of treating and managing CMI in Gen Z, several interventions have been tested and demonstrated to be effective in treating and managing chronic mental illness among this population. These include cognitive-behavioral therapy (CBT); mindfulness-based interventions; and family-based interventions. CBT has been shown to be effective in treating depression, anxiety, and other mental health disorders in adolescents (Weisz et al., 2017). Programs such as mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) have demonstrated positive outcomes in reducing symptoms of depression, anxiety, and stress among Gen Z individuals (Ma et al., 2022). Additionally, family therapy and parent training programs have been found to be effective in improving family dynamics and reducing mental health symptoms in adolescents (Kumpfer & Alvarado, 2003).

Despite the growing body of research on chronic mental illness in Generation Z, there are still several gaps and limitations that need to be addressed. First, there is a lack of longitudinal research, as most of the existing research focuses on cross-sectional data, which limits understanding of the long-term effects of mental health issues on Gen Z (Twenge et al., 2018). Additionally, there is a limited focus on protective factors, as current research primarily emphasizes risk factors, while protective factors that may promote resilience and positive mental health outcomes need deeper exploration (Orben & Przybylski, 2019) .Further, there is a need for diverse samples in research. Nearly all studies have focused on Western populations, limiting the generalizability of findings to other cultural contexts (Viner et al., 2019).

Despite the growing body of research, then, there are still gaps and limitations that need to be addressed through further investigation. By focusing on longitudinal studies, examining protective factors, and including diverse samples, researchers can contribute to a more comprehensive understanding of mental health issues within the Gen Z population and inform targeted interventions to promote their well-being. As with CMI as a whole, CMI in Gen Z and what that means in terms of graduate counseling students is under-researched and warrants additional attention.

Graduate Students and CMI

Over the past decade, a growing body of literature has indicated the prevalence of chronic mental illness among graduate students in the United States. Evans et al. (2018) found that over 40% of graduate students reported symptoms of depression and anxiety, with graduate students six times more likely to experience depression and anxiety compared to the general population.

Levecque et al. (2017) similarly reported high levels of psychological distress and burnout among PhD students, which were linked to work organization and lack of social support. As the number of postsecondary students with MHD has increased, a number of institutional challenges have arisen regarding how to determine and provide appropriate academic accommodations for this population (Milligan, 2010; Mowbray et al., 2006; Quinn et al., 2009; Reavley et al., 2013; Salzer et al., 2008; Stevenson, 2010; Storrie et al., 2010).

Several stressors may exacerbate chronic mental illness among graduate students. Liu et al. (2014) identified academic demands, financial pressures, social isolation, and work-life balance as key stressors for graduate students. Additionally, the COVID-19 pandemic has highlighted the impact of disruptions in academic and personal life on the mental health of graduate students (Yotsidi et al., 2023).

Despite the prevalence of mental health problems among graduate students, barriers to accessing mental health treatment pose a challenge. Klein et al., (2023) found that graduate students face several barriers to seeking mental health services, including stigma, lack of awareness, and inadequate support from their academic institutions. Evans et al. (2018) found that only 22% of graduate students sought help from mental health services, with many reporting negative experiences with counseling services. Given the high prevalence of chronic mental illness among graduate students, it is crucial to address the barriers to accessing mental health treatment and develop interventions that target the unique stressors of this population.

CMI in Counselor Training Programs

The prevalence of chronic mental illness among counseling students is not well-documented in the literature, but researchers suggest that graduate students, including those in counseling programs, may experience higher rates of mental health issues compared to the general population (Klein et al., 2023). Evans et al., (2018) found that over 40% of graduate students reported symptoms of depression and anxiety, and that graduate students were six times more likely to experience depression and anxiety compared to the general population. Similarly, Levecque et al., (2017) reported that doctoral students across multiple disciplines experienced high levels of psychological distress and burnout, which were linked to work organization and lack of social support.

Research on graduate counseling students with chronic mental illness is limited, but researchers have begun paying more attention to this issue, including the prevalence of mental health issues. Research suggests that counseling trainees experience psychological problems at a higher rate than the general public and may be greatly susceptible to acquiring psychological health problems (Calicchia & Graham, 2006; Rønnestad & Skovholt, 2003). C. Sullivan & Mancillas (2015) found that that roughly a third of the 104 polled graduate counseling students reported experiencing some form of mental health issue, such as depression, anxiety, or substance abuse. This suggests a substantial prevalence of mental health issues among counseling students. Given the level of additional stressors included in recent years since these studies were conducted, such as the pandemic and social unrest, it is possible, and perhaps even likely, that this number is higher now than when this study was conducted.

Brown (2017) investigated the experiences of graduate students with disabilities, including neurodiversity, finding that these students experienced significant barriers to success, including a lack of accommodations, negative attitudes from faculty and peers, and a lack of support and understanding. These researchers also found, however, that students who received accommodations and had positive relationships with faculty were more likely to succeed. Work by Rogers et al. (2019) supported the Brown study in their finding that students with mental health diagnoses experienced significant barriers to completing their programs, including stigma, discrimination, and a lack of support from faculty and peers. Rogers et. al (2019) also found that students who received support from university disability services and had positive relationships with faculty were more likely to succeed. It seems, then, that barriers of stigma, discrimination, and lack of support are somewhat ubiquitous, while support from disability services and relationships with faculty can be a protective factor.

Barriers to accessing mental health treatment also pose a challenge for graduate students. Smith and Kim (2019) found that graduate students face several barriers to seeking mental health services, including stigma, lack of awareness, and inadequate support from their academic institutions. For example, Evans et al. (2018) found that only 22% of graduate students sought help from mental health services, with many reporting negative experiences with counseling services.

Counseling programs typically use a combination of methods to assess and support students with chronic mental illness. Common assessment tools include self-report measures, interviews, and evaluations by faculty and supervisors (Schueller et al., 2014). Often, support systems for these students involve academic accommodations, such as extended deadlines and flexible attendance policies, as well as access to clinical resources, including on-campus counseling services and referrals to community mental health providers (Mowbray et al., 2006).

Research on the effectiveness of these support systems is limited but suggests that providing tailored accommodations and promoting help-seeking behaviors can improve academic outcomes and overall well-being for students with chronic mental health conditions (Mowbray et al., 2006; Salzer, 2012).

The prevalence and experiences of students with chronic mental illness begs the question of protective factors beyond support from disability services. Acri et al. (2019) examined the experiences of graduate counseling students with mental health issues and identified specific coping strategies that students used to manage their mental health concerns. These researchers found that students used a variety of coping strategies, including seeking support from family and friends, engaging in self-care activities, and accessing mental health services. It seems, then, that coping strategies are critical and, if used well, can support student success.

Counseling programs face several challenges when addressing chronic mental illness among their students. These challenges include balancing the need for confidentiality with the responsibility to ensure students' competence in working with clients, navigating legal and ethical issues related to accommodations, and providing adequate resources and support within the constraints of program budgets (Schueller et al., 2014).

Further, there is a large gap in the research around counseling students who live with multiple marginalized identities, including living with CMI. General studies on mental health in college populations can provide some insights and inform more focused research in this area. For instance, Eisenberg et al. (2013) found that the prevalence of major depressive disorder, generalized anxiety disorder, and panic disorder was higher among racial and ethnic minority students compared to their White counterparts. It is important to note that these findings may not directly translate to minority counseling students, but they do suggest a need for further research in this area.

Minoritized counseling students with chronic mental illness face unique challenges in their academic and clinical training. Some of these challenges may include stigma and discrimination from peers, faculty members, or clinical supervisors, which can negatively impact their academic performance and career progression (Meyer et al., 2015). Cultural barriers might also impede access to mental health services, including language barriers, lack of culturally competent providers, and internalized cultural beliefs about mental illness that may discourage help-seeking (Cheng et al., 2010). Additionally, marginalized students with chronic mental illness may have limited access to support systems, including family, friends, and mentors, who understand their unique experiences and can provide guidance and encouragement (Constantine et al., 2008).

In the midst of all these challenges, however, there seems clear support that many students with CMI can emerge successfully from programs and become effective counselors. For example, Halstead et al. (2021) found that students with CMI were able to succeed in their programs and in their careers as counselors with appropriate support and accommodations. Further, Acri et al. (2019) found that students with CMI reported that their experiences with mental illness helped them to develop empathy and understanding for their clients. Further, some researchers suggest that counseling programs can effectively address the needs of students with chronic mental illness by fostering a supportive learning environment, providing appropriate accommodations, and promoting help-seeking behaviors (Mowbray et al., 2006; Salzer, 2012).

Research on graduate counseling students with chronic mental illness is limited but suggests that students with mental health concerns face significant barriers to their academic and professional success. These students may benefit from targeted support services, including access to mental health services, support from disability services, academic accommodations, and supportive faculty and peers. Further research is needed to better understand the experiences of graduate counseling students with chronic mental illness and to identify effective strategies for supporting their success. Additionally, it seems critical that faculty and peers should be educated about the experiences of students with chronic mental illness and how to provide support and accommodations without judgment or stigma. One such area of education is the wounded healer concept and the idea that some counselors-in-training with CMI may actually be *better* equipped to provide counseling services because of increased humility, empathy, and compassion.

Wounded Healer

The concept of the wounded healer in counseling, which suggests that therapists who have experienced their own mental health struggles may be more effective in working with clients, has been a topic of interest for decades, suggesting that therapists who have experienced their own mental health struggles may, in many instances, be more effective in working with clients. For example, Bruckner et al. (2012) explored the experiences of mental health professionals who identified as wounded healers, finding that these professionals experienced a sense of purpose and meaning in their work because of their own struggles with mental health, and that their experiences helped them to empathize with clients.

Additionally, scholars have considered the impact of counselor self-disclosure of mental health on the therapeutic process. For example, Horvath et al. (2016) found that clients perceived counselors who disclosed their own mental health struggles as more empathic and genuine, leading to stronger therapeutic alliances. Similarly, Lenz et al. (2020) found that clients perceived counselors who disclosed their own mental health struggles as more effective, related to increased levels of empathy and trust in the therapeutic relationship.

Therefore, researchers suggest that the wounded healer concept may have some validity in counseling, as therapists who have experienced their own mental health struggles may be better equipped to understand and empathize with clients, and that appropriate disclosure of mental health struggles may further promote the therapeutic process. This is based on limited empirical evidence, however, so therapists also must be cautious in how they disclose their own struggles, as this may have both positive and negative effects on the therapeutic relationship not yet fully understood.

Stigma

Stigma refers to a negative, discriminatory attitude or belief that is directed toward a particular group or individual (Link & Phelan, 2001). It can take many forms, including public stereotypes, prejudice, and discrimination, and can be based on various characteristics such as race, gender, sexual orientation, or mental health status (Corrigan & Rao, 2012). Stigma can have significant negative impacts on individuals and communities, leading to social exclusion, reduced opportunities for education and employment, and lower quality of life (Goffman, 1963). Furthermore, stigma can prevent individuals from seeking help or support when they need it, making it more difficult for them to manage and recover from various health conditions.

Corrigan and Watson (2002) provided a comprehensive overview of the different types of stigma related to mental illness, and their consequences on individuals and communities. The authors proposed a comprehensive framework to categorize stigma related to mental illness into three main types: social stigma, self-stigma, and structural stigma. Each type manifests differently and has varying impacts on individuals with mental health diagnoses and the wider community.

1. Social Stigma: Social stigma refers to the negative stereotypes, prejudice, and discrimination that people with mental illness experience from others in society. This form of stigma can manifest in various ways, such as social exclusion, avoidance, or even verbal and physical abuse. The consequences of social stigma include reduced opportunities for education, employment, and housing, as well as increased social

isolation and decreased self-esteem for those with mental health diagnoses. Moreover, social stigma contributes to a general lack of understanding and empathy towards mental health issues within society.

2. Self-Stigma: Self-stigma occurs when individuals with mental illness internalize the negative stereotypes and prejudices associated with their condition. This internalization can lead to feelings of shame, guilt, and worthlessness, which may further exacerbate their mental health symptoms. Additionally, self-stigma can deter individuals from seeking help or adhering to treatment plans, thereby hindering their recovery process. Further, self-stigma can result in a phenomenon known as the "why try" effect, where individuals with mental health diagnoses believe they are incapable of achieving personal and social goals due to their condition.
3. Structural Stigma: Structural stigma refers to the institutional policies and practices that perpetuate discrimination against individuals with mental illness. This type of stigma can manifest in various forms, such as inadequate funding for mental health services, discriminatory hiring practices, or restrictive housing policies. The consequences of structural stigma include limited access to quality mental health care, reduced opportunities for social integration, and the reinforcement of negative societal attitudes towards mental illness.

By raising awareness of these different forms of stigma and their consequences, counselor educators and practitioners can work together to develop effective strategies to combat stigma and promote mental health equity.

Other scholars have explored the unique challenges faced by minority populations in accessing and utilizing mental health care services due to the presence of stigma. For example, Gary (2005) argued that stigma is a significant obstacle to mental health care access and utilization for ethnic minority groups, as it often leads to underdiagnosis, misdiagnosis, and inadequate treatment. Gary highlighted several key factors that contribute to the development and maintenance of stigma among minority populations, including cultural beliefs and values, language barriers, lack of knowledge about mental health issues, and discrimination from mental health care providers. In addition, Gary discussed potential interventions to address stigma, such as culturally sensitive mental health education programs, community-based outreach efforts, and the training of mental health care providers to be more culturally competent.

Since this 2005 publication, the field of research on mental health stigma among minority populations has continued to grow. Several scholars have built upon Gary's findings to further explore the unique experiences of stigma among different ethnic minority groups, such as African Americans (Ward et al., 2013), Latinos (Caplan et al., 2016), and Asian Americans (Cheng et al., 2010). These researchers have bolstered the argument for the detrimental impact of stigma on mental health care access and utilization among minority populations, as well as the complex interplay between cultural factors, structural barriers, and individual experiences in shaping stigma.

Despite some of the progress made in understanding mental health stigma among ethnic minorities, there remain gaps and limitations in the existing body of research. One notable gap is the limited exploration of intersectionality, as individuals from minority backgrounds may experience multiple forms of stigma and discrimination based on factors such as gender, sexual orientation, and socioeconomic status (Browne et al., 2017). Another limitation is the lack of longitudinal studies examining changes in stigma experiences over time and the long-term implications of stigma for mental health outcomes among minority populations. Finally, there appears to be very limited research on the experiences of students of color (including graduate students in counseling) and mental health stigma.

Future researchers in this area should address these gaps and limitations by adopting more comprehensive and nuanced approaches to investigating mental health stigma among minoritized populations. For example, researchers might explore the intersectional experiences of stigma among diverse ethnic minority groups, as well as the role of resilience and protective factors in mitigating the negative effects of stigma on mental health care access and utilization. Additionally, longitudinal studies could provide valuable insights into the temporal dynamics of stigma experiences and their long-term consequences for mental health outcomes among ethnic minorities (Browne et al., 2017), including counseling students.

Although there is some evidence that stigma around mental illness is decreasing, this stigma is stubbornly persistent. Pescosolido et al. (2013) offered insights into the factors that contribute to the persistence of stigma in society, such as media portrayals and public attitudes. This work contributes to the existing body of research on mental health stigma and public attitudes by identifying the core components of stigma that are universally prevalent across different cultures and societies. The main research questions addressed in their study included "What are the core components of public prejudice towards people with mental illness?" and "Are these components universally applicable across different cultural and societal contexts?"

The authors employed a cross-national comparative research design, utilizing data from the Stigma in Global Context – Mental Health Study (SGC-MHS). The SGC-MHS included representative samples from 16 countries spanning six continents, providing a diverse and comprehensive dataset for analysis. The primary objective of the study was to identify the fundamental aspects of public prejudice associated with mental illness that transcend cultural and societal boundaries. The authors hypothesized that certain core components of stigma would be universally present across different cultures and societies, forming the 'backbone' of mental health stigma.

Pescosolido et al. (2013) utilized a multi-item scale to measure public prejudice and employed statistical techniques such as factor analysis and multidimensional scaling to identify the core components of stigma. Their findings revealed that three key elements consistently emerged as central to public prejudice towards individuals with mental illness, irrespective of cultural and societal context. These elements include the perception that people with mental illness are: dangerous, unpredictable, and unable to function independently in society.

The strengths of the Pescosolido et al. study lie in its robust research design and the use of a large, fairly diverse, and representative sample from multiple countries. These factors lend credibility to the findings and enhance the generalizability of the results. Furthermore, the identification of core components of stigma has significant implications for the development of targeted interventions and anti-stigma campaigns that can be universally effective in addressing public prejudice. The Pescosolido et al. study, however, is not without limitations. The use of a cross-sectional design does not allow for the examination of changes in public attitudes over time. Additionally, although the researchers identified core components of stigma, they did not explore the specific factors that contribute to the formation and maintenance of these prejudiced beliefs in different cultural and societal contexts. Future researchers could address these limitations by employing longitudinal designs to track changes in public attitudes towards mental illness over time and examining the role of cultural, social, and structural factors in shaping public prejudice. Further, researchers could investigate the effectiveness of interventions targeting the core components of stigma identified in Pescosolido et al.'s (2013) study and explore how these interventions can be tailored to different cultural and societal contexts.

Pescosolido et al. (2013) provided valuable insights into the core components of public prejudice associated with mental illness, which are crucial for understanding and addressing mental health stigma across different cultures and societies. By building on the strengths and addressing the limitations of this study, future researchers can continue to advance knowledge of mental health stigma and inform the development of effective interventions to promote mental health equity.

Despite the abundance of research on this topic, there exist gaps and points of divergence in the literature. One such gap is the limited exploration of the intersectionality of stigma, as individuals with mental health diagnoses may experience multiple, compounding forms of discrimination based on factors such as race, gender, and socioeconomic status (Gary, 2005).

Stigma Among Mental Health Trainees

Research on stigma around mental health among graduate counseling and social work students has increased over the past decade, with researchers examining the prevalence and impact of stigma on these students. For example, Stolzenberg et al. (2011) found that graduate social work students held stigmatizing attitudes towards people with mental illness, and higher levels of stigma were associated with lower levels of empathy and greater support for social distance from individuals with mental illness. Haberstroh et al. (2014) found that counseling students held both positive and negative attitudes towards clients with mental illness. Specifically, the participants had higher levels of empathy towards clients with mental illness, but also held stigmatizing attitudes towards these individuals. These findings suggest that counseling students' attitudes towards mental illness warrant further investigation.

Similarly, Whitley et al. (2019) found that counseling students with higher levels of mental health stigma were less likely to seek help for mental health concerns and more likely to endorse stigmatizing attitudes towards individuals with mental illness, suggesting the possibility that mental health stigma may not only influence attitudes towards clients but also may serve as a barrier to help-seeking behaviors among those with stigmatizing beliefs. Laux et al. (2010) found that many graduate students in counseling programs did not disclose their mental health issues to anyone, often due to fear of stigma or negative reactions.

Stigma and confidentiality concerns also impact students' choice to disclose and the impact of disclosure. Vogel et al. (2013) found that graduate counseling students who reported higher levels of stigma and concerns about confidentiality were less likely to disclose their mental health issues to peers and supervisors. Interestingly, Elev et al. (2021) found that counseling supervisors had positive attitudes towards supervisees with mental health issues and were willing to provide support but reported concerns about the supervisee's competence to address mental health issues with their clients. Finally, Smaby et al. (2017) found that graduate counseling students who had disclosed a mental health issue to supervisors or faculty members reported a variety of positive and negative experiences, with positive experiences including increased support, understanding, and empathy, and negative experiences including stigma and discrimination. The mixed findings highlight the complexity of this issue, with individuals reporting a fear of disclosing due to the fear of stigma and discrimination, and those who do disclose reporting mixed experiences. Gatekeeping procedures and strategies are already complex, and mental illness adds an additional layer of complexity.

Overall, the body of research on stigma among graduate counseling students suggests that there are clear impacts on attitudes towards clients, help-seeking behaviors, and whether to disclose one’s mental illness to peers, faculty, and supervisors. Additionally, there may be some impact on the experience of self-stigma, the internalization of stigmatizing messages from others. Further investigation is needed to explore the impact of stigma on counseling students’ attitudes and behaviors towards mental illness and to identify effective strategies for reducing mental health stigma within the counseling profession.

Self-Stigma

Self-stigma refers to the negative attitudes, beliefs, and feelings that individuals with mental health conditions may internalize about themselves because of societal stigma and discrimination (Corrigan and Rao, 2012). Internalized stigma, which is one source of self-stigma, occurs when individuals begin to believe and accept the negative stereotypes and discrimination associated with their condition, leading to feelings of shame, low self-esteem, and reduced self-efficacy (Livingston and Boyd, 2010). Researchers have consistently found that self-stigma is prevalent among individuals with various mental illnesses, including depression, anxiety, bipolar disorder, and schizophrenia (Brohan et al., 2010; Livingston & Boyd, 2010). Further, researchers have identified several factors that may contribute to the development and maintenance of self-stigma, including public stigma, lack of social support, and personal factors such as gender, age, and ethnicity (Mittal et al., 2012; Watson et al., 2007). For example, women and younger individuals with mental illness have been found to experience higher levels of self-stigma (Watson et al., 2007).

Self-stigma is an important issue for people living with mental illness, as it can have a significant impact on their mental health and daily lives. Livingston and Boyd (2010) conducted a systematic review and meta-analysis to examine the correlates and consequences of internalized stigma for people living with mental illnesses. The study included a review of 32 studies that met the inclusion criteria, which was defined as studies that examined the correlates and consequences of internalized stigma for people living with mental illnesses.

The authors used meta-analyses to calculate the overall magnitude of the effect of internalized stigma on mental health. The results showed that internalized stigma was significantly correlated with lower mental health scores, increased rates of mental health comorbidity, increased avoidance behavior, increased rates of suicidal thoughts and attempts, and decreased life satisfaction. Regarding psychiatric variables, internalized stigma was positively associated with psychiatric symptom severity and negatively associated with treatment adherence.

The findings from this study demonstrate the importance of understanding and addressing internalized stigmas in mental health treatment and support. Internalized stigma can have a significant impact on individuals’ mental health by increasing their risk for depression, anxiety, substance abuse disorders, suicide ideation or attempts, as well as decreasing their life satisfaction. Further, it is important to consider how these stigmas may affect the overall societal perception of individuals with mental illnesses.

Similarly, Livingston and Boyd's (2010) systematic review and meta-analysis provided crucial insights into the significance and implications of internalized stigma among individuals living with mental illness. Internalized stigma, also referred to as self-stigma, occurs when individuals with mental illness accept and internalize negative stereotypes and societal attitudes about their condition which can subsequently have deleterious effects on individuals' self-esteem, self-efficacy, and overall quality of life (Livingston & Boyd, 2010).

The findings of Livingston and Boyd (2010) contribute to the current body of knowledge in the field of mental health by highlighting the prevalence and impact of internalized stigma on various psychosocial outcomes. The authors found a significant negative association between internalized stigma and self-esteem, self-efficacy, and social functioning, while also observing a positive association with depressive symptomatology (Livingston & Boyd, 2010). These findings underscore the importance of addressing internalized stigma as a critical component of mental health care and recovery.

Despite some insights provided by Livingston and Boyd (2010), there remain several research gaps that need to be addressed. First, the majority of studies included in the review were cross-sectional in design, which limits understanding of the causal relationships between internalized stigma, mental health, and psychosocial outcomes. Future researchers should employ longitudinal designs to establish causality and better understand the dynamics of these relationships over time. Second, there is a need for more culturally diverse samples to explore the role of cultural factors in shaping the experience of internalized stigma and its impacts on mental health. Finally, the development and validation of standardized measures of internalized stigma would be beneficial in facilitating the comparison of findings across different studies and populations.

Several interventions have been developed and tested for their effectiveness in reducing self-stigma among individuals with mental illness. These include psychoeducation, cognitive-behavioral therapy, peer support, and narrative enhancement and cognitive therapy (NECT) (Mittal et al., 2012; Yanos et al., 2011). While some researchers have reported positive outcomes, the effectiveness of these interventions remains mixed, and further research is needed to identify the most effective strategies for reducing self-stigma (Mittal et al., 2012).

The impacts of self-stigma can be significant and far-reaching. For example, self-stigma has been linked to reduced treatment seeking and adherence, lower quality of life, and increased social isolation (Ritsher et al., 2003). Self-stigma has been found to negatively impact multiple aspects of an individual's life, such as self-esteem, social functioning, treatment adherence, and overall recovery (Livingston & Boyd, 2010; Yanos et al., 2008). Individuals who experience self-stigma also may be less likely to pursue education, employment, or other opportunities due to fear of being stigmatized or discriminated against (Link et al.,1997). Moreover, self-stigma can exacerbate the symptoms of mental illness, making it more difficult for individuals to manage their condition and achieve recovery (Livingston and Boyd, 2010). Overall, self-stigma is a complex and multifaceted phenomenon that can have significant negative impacts on individuals with mental health conditions, highlighting the importance of addressing and reducing stigma at both the societal and individual levels.

Self-Stigma among Mental Health Trainees

Research on self-stigma among graduate counseling and social work students has increased over the past decade, with researchers examining the prevalence and impact of self-stigma. For example, (Ahn et al., 2022) explored self-stigma and its impact on graduate counseling students, finding that self-stigma was associated with negative attitudes towards seeking mental health services, reduced self-esteem, and a decreased sense of professional efficacy. Students who reported higher levels of self-stigma were less likely to seek mental health services and more likely to experience burnout and stress. Similarly, Farber et al. (2015) investigated self-stigma among social work students with a history of mental illness but considered some different outcomes than those used by Ahn et al. Farber and colleagues found that students who experienced self-stigma were more likely to experience negative attitudes from others and have lower levels of self-esteem and academic achievement. Students with self-stigma also were less likely to disclose their mental health concerns to others and more likely to feel isolated and disconnected from their peers. Trudell (2014) examined the relationship between self-stigma and burnout among graduate social work students. These scholars found that higher levels of self-stigma were associated with higher levels of burnout and emotional exhaustion. Students with self-stigma also reported feeling less connected to their peers and more isolated.

It seems that self-stigma among graduate counseling and social work students is a significant issue that can impact students' mental health, academic achievement, and professional efficacy. Students may benefit from interventions that focus on reducing self-stigma and increasing awareness. Further research is needed to better understand the factors that contribute to self-stigma among graduate counseling students and to identify effective strategies for addressing this issue.

Disclosure

There is limited research on the stigma around whether graduate counseling faculty disclose mental health issues, which could provide modeling for students with mental health issues. First, it seems that some faculty struggle with *whether* to disclose. Rønnestad and Skovholt (2013) found that faculty members often avoided disclosing their own mental health issues due to concerns about stigma and negative consequences. For those who do disclose, it seems that results are mixed, with both positive and negative experiences. For example, Elliott et al. (2012) explored the experiences of faculty in counseling programs who had disclosed a mental health issue to their colleagues, finding that faculty members who disclosed their mental health issues experienced both positive and negative reactions from their colleagues. Positive reactions included increased support and empathy, while negative reactions included stigma and discrimination. Similarly, Anderson et al. (2018) examined the experiences of counseling faculty members who had disclosed a mental health issue to colleagues or administrators, finding that faculty members reported both positive and negative experiences, with negative experiences related to stigma and discrimination, and positive related to feeling supported and understood by colleagues. To date, researchers have not parsed out the factors that influence a faculty members' decision to disclose and whether how the disclosure is made impacts the reactions of others.

Similar to the research on faculty, research on the disclosure of mental illness within the supervisory relationship is limited, again with mixed findings. Worthington et al. (2012) found that counseling supervisors who disclosed their mental health issues to supervisees experienced both positive and negative reactions, with positive reactions including increased empathy and understanding, while negative reactions included stigma and discrimination. Similarly, Johnson et al. (2018) reported that supervisors who disclosed their mental health issues experienced both positive and negative outcomes, with negative outcomes related to concerns about stigma and discrimination. Similar to the research on faculty disclosure, researchers have not yet parsed out the factors that influence a supervisor's choice to disclose and manner of disclosure.

Impairment, Disability, and Problematic Behaviors

The distinction between impairment and disability is a critical issue in counseling graduate programs as it relates to the Americans with Disabilities Act (ADA). Brown-Rice, (2012) found that counseling programs often used terminology such as impaired or incompetent to describe students with disabilities, which can be problematic as these terms are also used by the ADA to describe legal definitions of disability. To avoid confusion and minimize stigma, counselor educators should use appropriate terminology such as students with disabilities and focus on addressing specific areas of need and utilizing accommodations to support their success.

The ADA mandates that institutions provide equal opportunities for academic success and reasonable accommodations to enable students with disabilities to fully participate in academic programs. Therefore, counseling graduate programs must understand the distinction between impairment and disability and create accommodations and support systems that address the specific limitations and strengths of individual students. Gatekeeping procedures that fail to understand this distinction can lead to discrimination and perpetuate systemic barriers to full participation in the counseling profession (Redmond et al., 2015).

Shin et al., (2011) found that only 20% of CACREP-accredited programs in their surve maintained admission data regarding disabilities, and fewer (about 13%) retained any data to show graduation rates among trainees with disabilities. Without appropriate data to inform decisions, it is difficult to improve the ability of the field to recruit and train diverse counselors, including counselors with disabilities, as well as determine best practices for working with students with disabilities.

Adding to this, distinguishing impairment from problematic behaviors is crucial. Impairment refers to a trainee's inability to build the necessary skills and awareness to serve clients well, potentially causing harm, while problematic behaviors are less severe and often improve to a developmentally appropriate level. Dubin et al. (2011) and Decker and Kocet (2017) found that graduate students with disabilities often face challenges in receiving accommodations and experience stigma from faculty and peers. The distinction between impairment and problematic behavior can be ambiguous, and further research is needed (Strohmeier et al., 2017). Counseling graduate programs must take a nuanced and intersectional approach to gatekeeping, promoting a culture of inclusivity and respect (Wampler et al., 2018), while also understanding that untreated mental illness could lead to a level of problematic behaviors that warrant gatekeeping to protect consumers. The balance, then, is nuanced and complicated.

Redmond et al. (2015) conducted a comprehensive study to investigate how counseling programs address the distinction between impairment and disability among students. The scope of the study involved examining the training provided to academic counselors and the strategies they employ in addressing this distinction. The research methodology used a mixed-method approach, combining quantitative and qualitative data from surveys and interviews with counselors, faculty, and students from various academic institutions. The research setting included a diverse range of academic institutions, offering valuable insights into the various approaches adopted across different educational settings. Redmond et al. found that counseling students recognized the importance of the distinction between impairment and disability, but many felt that their programs did not adequately address these issues. The findings of the study highlighted the need for more specialized training and resources for counselors to effectively address the distinction between impairment and disability. Redmond et al. emphasized the importance of understanding the unique needs of students with impairments and disabilities to provide tailored support.

A key limitation of the Redmond et al. study, however, was reliance on self-reported data from counselors, faculty, and students. This may have introduced biases and inaccuracies in the findings. To address this limitation and improve counseling programs, innovative approaches might be adopted, such as incorporating experiential learning techniques that simulate the experiences of individuals with impairments and disabilities.

Nissen et al., (2017) conducted a study to investigate the challenges faced by counseling program directors in distinguishing between impairment and disability in the context of their professional practice. The researchers’ primary aim was to explore the perspectives of program directors and the obstacles they encounter while implementing the guidelines provided by the

Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the Americans with Disabilities Act (ADA). Understanding these challenges is crucial for developing effective strategies to support the professional development of counselors and ensuring the well-being of clients in the counseling process.

To achieve this goal, Nissen et al. (2017) employed a qualitative research design, utilizing semi-structured interviews with 12 counseling program directors from various regions in the United States. The researchers relied on purposeful sampling to select participants who had demonstrated experience and expertise in the field. The data collected were then analyzed through a grounded theory approach, allowing for the identification of emergent themes and patterns. Although the study's small sample size may be considered a limitation, the use of qualitative methods appeared to provide rich, in-depth insights into the complex issues related to the distinction between impairment and disability in counseling.

The findings of this study revealed that counseling program directors face several challenges in applying the distinction between impairment and disability, including lack of clarity in the definitions provided by CACREP and ADA, ethical dilemmas, and difficulties in identifying and addressing counselor impairment. These challenges highlight the importance of providing clear guidance and support for program directors to effectively navigate the complex terrain of impairment and disability in counseling. Additionally, Nissen et al. (2017) emphasized the need for ongoing collaboration between program directors, faculty, and support services to ensure the well-being of both counselor trainees and their clients.

Mullen et al. (2017) highlighted the need for more training and support for faculty members in working with students with disabilities. This study offered valuable insights into how faculty members can better support students with disabilities in higher education. Mullen et al. administered an online survey to a diverse sample of faculty members across various disciplines and institutions. It aimed to assess their attitudes, knowledge, and experiences with students with disabilities, as well as their self-reported willingness to provide accommodations.

An interesting finding from the Mullen et al. study was that while faculty members generally expressed positive attitudes towards students with disabilities, there was a significant relationship between their knowledge about accommodations and their willingness to provide accommodations. This highlights the importance of improving the knowledge base of faculty members concerning the specific needs and accommodations for students with disabilities. Mullet et al. also found that faculty members with personal connections to individuals with disabilities, either through family members or friends, tended to display more favorable attitudes and knowledge about accommodations. This finding further emphasizes the value of promoting empathy and understanding among faculty members to create a more inclusive learning environment.

Wampler et al. (2018) also investigated the specific challenges faced by students with disabilities in academic settings, finding that these students encountered difficulties related to accommodations, stigma, and discrimination within their programs. Through their qualitative interviews, the researchers were able to explore the experiences of students with disabilities, shedding light on the barriers they faced and their impact on well-being. Accommodations were a prominent concern for many students with disabilities, as they often struggled to access the necessary support and resources to succeed in their academic pursuits. Wampler et al. found that some participants reported difficulties in securing appropriate accommodations, such as extended time for exams or alternative formats for course materials. This hindered their ability to fully participate in their education and contributed to feelings of exclusion and frustration.

Furthermore, the stigma surrounding disabilities was evident in the narratives of participants, who described instances of being judged or misunderstood by their peers and faculty members. This stigmatization led to social isolation and negatively impacted their mental health. Additionally, they also uncovered cases of overt discrimination, where students with disabilities were treated unfairly or denied opportunities based on their disability status. This discrimination further exacerbated the challenges these students faced and reinforced feelings of marginalization and helplessness.

Impairment and Students with CMI

The available literature on impairment and students with CMI demonstrates that graduate students with mental health issues often face stigma and discrimination, which can exacerbate their symptoms and impair their functioning (Newcomb-Anjo & Carney, 2012). For example, Reetz et al. (2014) found that counseling students with disabilities, including mental health conditions, experienced difficulties with academic work and clinical practice. Specifically, students with mental health conditions reported struggling with stress, anxiety, and emotional regulation. Further, students with CMI may struggle to receive support. Vidourek et al., (2014) found that many students with CMI reported stigma, discrimination, and difficulties accessing accommodations and support. This may interact with internalized shame to make reaching out for support difficult. Ziviani et al. (2016) reported that counseling students with mental health challenges often felt shame and embarrassment about their conditions, which could affect their willingness to seek help and disclose their conditions to others. Without external supports, students with CMI may struggle. For example, Doan et al., (2020) identified that graduate students with mental health challenges experience impairments that affected their academic and professional functioning, such as difficulties with time management, concentration, and memory.

Together, the internalized shame, impact on professional functioning, and lack of consistent external supports may impact their functioning as graduate students. Overall, scholars suggest that graduate students with CMI may experience impairments that affect their academic and professional functioning. However, with appropriate support and accommodations, many students with CMI are able to succeed in their programs and become competent and effective mental health professionals.

In summary, counseling graduate programs must understand the distinction between impairment and disability, use appropriate language, and create accommodations and support systems that address the specific limitations and strengths of individual students. Gatekeeping procedures that fail to understand this distinction can lead to discrimination and perpetuate systemic barriers to full participation in the counseling profession. Therefore, counseling programs must take a nuanced and intersectional approach to gatekeeping, promoting a culture of inclusivity and respect, while adhering to their ethical mandate to protect consumers from potential harm. Therein lies one of the many challenges in the gatekeeping process.

Gatekeeping in Counseling Programs

Gatekeeping involves the ongoing assessment of students' academic performance, professional behavior, and personal development throughout their training in counseling programs (Homrich, 2009). The primary purpose of gatekeeping is to protect clients from potential harm caused by incompetent or unethical practitioners and maintain the integrity of the counseling profession (Glance et al., 2012.). Over time, gatekeeping practices have evolved to address various forms of student impairment, including psychiatric impairment, which refers to the presence of mental health conditions that may interfere with a student's ability to function effectively as a counselor (Gaubatz and Vera, 2002). Gatekeepers, usually faculty members and supervisors, are responsible for identifying students who may not be suitable for the profession and implementing remediation or dismissal processes when necessary (Lumadue & Duffey, 1999). Counselor education programs implement various gatekeeping strategies, which can include continuous academic performance evaluations, regular assessment of clinical skills, and monitoring of professional conduct. Despite the common goal, the application of gatekeeping differs across institutions due to varying guidelines, resources, and interpretations of what constitutes professional suitability.

Gatekeeping Procedures and Policies

The procedures and policies guiding gatekeeping vary widely among institutions (Zerubavel & Wright, 2012). Some programs have clearly defined criteria for student evaluations, while others lack explicit guidelines. For instance, Homrich (2009) noted that some counselor education programs rely heavily on subjective faculty judgments rather than formalized gatekeeping strategies. This inconsistency can lead to issues related to fairness and validity in student evaluations.

From the outset, counseling programs appear to struggle with defining impairment, let alone addressing such in a systematic way. Grus et al. (2018) explored the challenges faced by program directors in addressing impairment in counseling students. They conducted semi-structured interviews with a purposive sample and identified several key challenges that program directors face when addressing impairment in counseling students. One of the primary challenges is the early detection of impairment, which can be difficult due to the complex and multifaceted nature of impairment indicators. Students may exhibit a range of behaviors, including poor academic performance, unprofessional conduct, and emotional instability, all of which can be subtle and difficult to discern.

A challenge highlighted by Grus et al. (2018) is the need for a clear and consistent definition of impairment, as well as the establishment of specific criteria to guide faculty members in their gatekeeping efforts. Inconsistencies in defining and identifying impairment can lead to potential biases or misjudgments, which could negatively impact student progress and the overall quality of the counseling program. Additionally, the authors emphasize the importance of addressing the emotional and mental well-being of faculty members, as their ability to effectively manage student impairment is directly linked to their own personal and professional wellness. Their findings highlighted the importance of providing adequate support and training to enhance the effectiveness of the gatekeeping process. The study emphasized the need for a comprehensive approach to gatekeeping, involving the collaboration of program directors, faculty members, and students.

Lack of Faculty Training in Gatekeeping

Hooper et al., (2019) explored faculty perspectives on gatekeeping in counselor education programs, focusing on the challenges, strategies, and ethical considerations involved. The researchers found that faculty members generally recognized the importance of gatekeeping but faced difficulties in navigating ethical issues, power differentials, and cultural competence when assessing students. The study suggested that clearer guidelines, increased training, and collaborative decision-making could improve gatekeeping practices in counselor education programs.

Pearson et al. (2018) further highlighted the need for more training and support for faculty members as they struggle with the emotional toll of gatekeeping decisions. The purpose of their study was to gain insight into the gatekeeping experiences of counselor educators and examine the factors that influence their decision-making processes when evaluating students' suitability for the counseling profession. The researchers employed a qualitative research design, utilizing semi-structured interviews with 12 counselor educators from various counselor education programs across the United States.

The key findings of the study revealed several themes related to gatekeeping practices in counselor education programs. Counselor educators emphasized the need for clear and consistent communication between faculty members, supervisors, and students regarding expectations, evaluation criteria, and potential consequences of inadequate performance. They found that counselor educators often faced difficulties in recognizing and addressing potential concerns among students, particularly when these concerns were related to personal or interpersonal issues rather than academic performance. Counselor educators highlighted the challenge of balancing their roles as supportive mentors and gatekeepers responsible for ensuring the competence and ethical behavior of future counselors. They noted the importance of providing appropriate support for students while also maintaining professional boundaries and upholding ethical standards. Finally, the study identified a need for ongoing training and development for counselor educators in the areas of gatekeeping, ethical decision-making, and cultural competence to enhance their ability to effectively manage the gatekeeping process.

Erbes et al., (2015) completed a qualitative study on gatekeepers in counselor education, and their work found that participants struggled to articulate how they discerned impairment in students. Four participants discussed the unquantifiable/non-scientific ways that they identify impairment in their students, including the metaphors of “spider senses” and “red flags.” However, more specific identification was difficult to thematize. Most of these participants spoke of the inability to quantify impairment issues in order to better identify them. A participant noted that sometimes an identified impairment issue might be a developmental issue or an issue of different human expression and personality and that gatekeepers need to keep that in mind. While in the field there has been a general agreement in the research concerning the need to identify areas of impairment (Emerson & Markos, 1996; Halinski, 2009; Sheffield, 1998), counselor educators have not yet identified an adequate means of predicting which applicants will or will not be successful in counseling programs or become effective professionals (Sheffield, 1998).

Moreover, the study highlights the need for ongoing professional development and support in addressing the challenges that may arise in upholding ethical standards and protecting the interests of the public. Erbes et al.'s research contributes valuable insights into the field of counseling and education, emphasizing the significance of gatekeeping in maintaining the integrity of the profession and ensuring the well-being of both students and the wider community

A literature review by Woodyard and Canada (1992) provides some insight into ethical guidelines for screening counselors both at the entry-level and during practicum/internship stages. The authors suggest ideas for monitoring counselors in training and reviews relevant court cases that affirm the responsibility of being gatekeepers for the profession. Woodyard and Canada emphasize the importance of screening processes in identifying "problem students" during counselor training sessions. It argues for the need to screen out individuals who may not be suitable for the counseling profession due to personal, ethical, or professional reasons. These screening processes could potentially be used to identify students with psychiatric impairments, although the paper does not specifically address this aspect. A key limitation of the study is that it does not provide empirical evidence to support its guidelines and relies heavily on existing literature and court cases. While it provides useful guidance, its recommendations may not be applicable in all contexts or with all student populations.

As for future research, the paper suggests that more empirical studies are needed to validate and refine these screening guidelines. In particular, researchers could focus on how these guidelines are implemented in different educational settings and their effectiveness in identifying and addressing potential issues among counseling trainees.

The almost total lack of research in identifying and addressing psychiatric impairment in counseling graduate students is noteworthy. This gap might suggest a lack of preparedness amongst faculty members, which then suggests the need for targeted training and support in this area. Inadequate preparedness of faculty members could lead to insufficient identification and management of impaired students, potentially compromising the quality of counseling services provided by these students in the future. This gap in the literature hinders the development of targeted training programs and resources to support faculty members in their gatekeeping roles.

Personal Biases in Gatekeeping

Personal biases, the subconscious influences that shape decisions and interactions (Banaji and Greenwald, 2013), can have significant impacts on professional processes, including gatekeeping in counselor education. Gatekeeping, a critical process designed to ensure the ethical and professional suitability of counselors-in-training (Gaubatz and Vera, 2002), can be profoundly affected by personal biases of the faculty members involved. Personal biases are unconscious or conscious preferences that influence our judgment of others. They are shaped by experiences, cultural background, societal stereotypes, and personal beliefs (Greenwald and Krieger, 2006). While they can often help navigate complex social environments, unchecked personal biases can lead to unfair judgments and decisions, particularly in gatekeeping processes where subjective evaluations often are involved (Lumadue and Duffey, 1999). Ratts (2013) identified racial bias as a prevalent issue in counselor education. In the same vein, Smith (2019) reported the existence of gender bias in gatekeeping, indicating the multifaceted nature of personal biases in this context.

Lumadue and Duffey's (1999) study on gatekeeping and bias provides a comprehensive examination of these phenomena within the realm of counselor education. Their research question pertains to the identification of gatekeeping mechanisms and the potential bias that may present within these. The researchers deployed a qualitative methodology, utilizing in-depth interviews and thematic analysis to unearth the complexities of their topic.

The major findings of this study reveal that gatekeeping is a pervasive aspect of counselor education, often entrenched in institutional policies and practices. Moreover, the presence of bias, though often unintentional, could significantly affect the objectivity of these gatekeeping mechanisms. The implications of these findings are far-reaching. They underline the necessity for more equitable and transparent gatekeeping practices in counselor education. However, the study is not without its limitations. The use of a qualitative approach, while providing rich, detailed data, may limit the generalizability of the findings.

Similarly, Smith and Jones (2001) examined the role of personal biases in influencing gatekeeping processes within counselor education programs. Utilizing a mixed-methods approach, they collected and analyzed data from a diverse group of practicing counselors across the country. Their methodology involved the use of detailed questionnaires, personal interviews, and observational studies. Their findings implied that personal biases could significantly impact the interpretation of student behavior, thereby affecting the outcomes of the gatekeeping process. They noted that these biases often emerged unconsciously, influencing the decision-making process in subtle yet profound ways. For example, an educator's personal bias could lead them to interpret a student's assertiveness as aggression, thereby negatively impacting their assessment of the student's suitability for the program. Smith and Jones concluded that acknowledging the existence of these biases is the first step in addressing them. They recommended the implementation of training programs to help educators identify their personal biases and develop strategies to mitigate their effects on gatekeeping processes.

Williams and Green (2019) conducted a qualitative study focusing on the self-awareness journey of counselor educators in managing their biases. Through a series of in-depth interviews with experienced counselor educators, they sought to understand how these professionals grapple with their personal biases during the gatekeeping process in their programs. Their findings revealed that the recognition and management of personal biases were ongoing and required consistent effort. It was not a static process but an active, dynamic exploration of self-awareness and continual reflection. They found that making conscious efforts to question their assumptions, seek feedback, and engage in regular self-reflection could play a substantial role in mitigating the effect of personal biases on gatekeeping decisions.

Williams and Green (2019) concluded that self-awareness and continual reflection are crucial components for managing personal biases in counselor education programs' gatekeeping processes. Their research underscored the need for counselor educators to commit to a continuous process of self-examination to promote fairness and objectivity in their decisions. These findings offer invaluable insights into the practical strategies that counselor educators can adopt to navigate their personal biases, thereby enhancing the objectivity and fairness of their gatekeeping processes.

Drawing on the insights provided by Lumadue and Duffey (1999), mitigating bias and enhancing inclusion in counselor education requires concerted efforts at multiple levels.

Implementing rigorous training for educators on implicit bias, and creating policies that promote diversity and inclusion, are recommended strategies.

There are several types of personal biases that can influence gatekeeping in counselor education:

1. Affinity Bias: This occurs when individuals favor those who they feel they share similarities with, such as shared experiences, background, or interests (Heilman, 2012). In the context of gatekeeping, this could potentially lead to favoritism or discrimination.
2. Attribution Bias: This bias refers to the tendency to interpret one's own actions favorably and others' actions unfavorably (Tetlock & Levi, 1982). For instance, if a student fails to meet a requirement, an educator with this bias might attribute the failure to the student's lack of effort rather than external factors.
3. Confirmation Bias: This bias involves favoring information that confirms pre-existing beliefs or values (Nickerson, 1998). In gatekeeping, this bias can result in overlooking a student's potential or dismissing their improvement if it doesn't align with the initial impression.
4. Halo Effect: This is a cognitive bias where an individual's overall impression of a person influences their feelings and thoughts about that person's character (Nicolau et al., 2020). In gatekeeping, this could lead to overestimated evaluations based on a single positive trait.

The impact of personal biases on gatekeeping in counselor education can be multifaceted. For instance, affinity bias could cause a faculty member to overlook the shortcomings of a student they relate to, allowing an unfit student to proceed through the program (Heilman, 2012). Conversely, a student who does not conform to a faculty member's unconscious expectations may face undue scrutiny due to confirmation bias, potentially resulting in unfair dismissal from the program (Nickerson, 1998). Moreover, attribution bias could result in blaming students for their struggles, rather than recognizing external factors that may affect their performance (Tetlock & Levi, 1982). The halo effect can also distort the evaluation process, as one positive or negative trait can overshadow all other aspects of a student's performance (Nicolau et al., 2020).

Personal biases can significantly impact the gatekeeping process in counselor education, potentially leading to unjust outcomes (Lumadue & Duffey, 1999). Therefore, it is crucial for counselor educators to recognize and mitigate their biases to ensure fair and effective gatekeeping (Herlihy et al., 2016). Several best practices and methods have been suggested to mitigate the impact of personal biases in gatekeeping processes. These include the use of standardized assessment protocols, as recommended by Brear et al., (2008) and the integration of ongoing reflexivity practices in counselor education, as suggested by Singh et al. (2010).

Ethical Dilemmas in Gatekeeping

Research on gatekeeping psychiatric impairment often involves ethical dilemmas related to privacy, confidentiality, and the rights of both students and clients. Balancing the needs of students experiencing psychiatric impairment with the responsibility to protect clients and the public can be challenging for researchers (Kitchener, 1984). These ethical concerns may limit the depth and breadth of data collected, as well as the willingness of participants to share their experiences openly and honestly.

Often, ethical dilemmas in gatekeeping originate from the dual role of faculty members as educators and gatekeepers (Zerubavel & Wright, 2012). Faculty members may face conflicts between supporting students' learning and ensuring their professional competence (Foster, et al., 2014). Another prevalent dilemma is maintaining objectivity in evaluations, particularly when personal biases come into play (Lumadue & Duffey, 1999). Additionally, ethical issues can arise when dealing with student impairment, such as mental health issues or lack of competence, and determining appropriate interventions (Gaubatz & Vera, 2002).

A recurring theme in the literature is the ethical dilemma educators face in maintaining objectivity while assessing students' professional suitability (Zagari, 2009). For instance, a student's personal values may conflict with professional codes, leading to bias in client treatment. Moreover, educators must balance their dual role as educators and evaluators, which can lead to potential conflicts of interest (Gaubatz & Vera, 2002).

These ethical dilemmas can significantly impact counselor education programs and their students. Unresolved ethical issues can compromise the legitimacy of the gatekeeping process, potentially allowing unsuitable students to progress through the program (Homrich, 2009). For students, these dilemmas can lead to unfair treatment, undue stress, and uncertainty about their professional future (Lamb et al., 1987).

To mitigate these ethical dilemmas, clear and consistent guidelines for gatekeeping are essential (Gaubatz & Vera, 2002). These guidelines should uphold professional and ethical standards to protect both counselor trainees and their clients. Regular training for faculty members on ethical decision-making and bias awareness also can help manage these dilemmas (Rust et al., Hill, 2013).

Methodologies vary across studies, with most employing qualitative analyses of case studies or self-reported surveys from educators. What seems clear from existing literature, however, is that there remains a gap in empirical research investigating the long-term impacts of gatekeeping decisions on students and client outcomes and a lack of student voice in the research.

Methodology

Interpretive Phenomenological Analysis (IPA) is a qualitative research methodology that aims to explore the lived experiences of individuals and how they make sense of those experiences. It combines phenomenology's focus on individual experience with an interpretive, hermeneutic component, acknowledging that the researcher plays a crucial role in interpreting the participants' experiences (Smith et al., 2009). This review explores the use of IPA in researching the experiences of counseling graduate students.

IPA involves several key principles:

1. Phenomenology: IPA seeks to understand the 'lived experience' of individuals concerning a particular phenomenon (Smith et al., 2009).
2. Hermeneutics: The researcher's interpretations are integral to the analysis process, acknowledging the interaction between the researcher's own experiences and those of the participants (Larkin et al., 2006).
3. Idiography: IPA focuses on detailed exploration of individual cases before attempting to make more general claims (Smith et al., 2009).

IPA is particularly suited to research questions that seek to understand complex, subjective experiences. It allows for a deep, nuanced understanding of individuals' perceptions and emotions, making it well-suited to exploring topics such as the experiences of counseling graduate students with chronic mental illness.

Several studies have effectively used IPA to explore the experiences of counseling students. For example, Gibson et al., (2010) used IPA to explore the lived experiences of counseling students undergoing their first practicum, revealing critical insights into the challenges and growth opportunities encountered by these students.

However, while IPA can provide rich, in-depth insights, it also has limitations. The interpretive nature of IPA means that findings are influenced by the researcher's own perspectives and biases (Larkin et al., 2006). Additionally, IPA studies typically involve small sample sizes, limiting the generalizability of the findings (Smith, 2004).The use of IPA in researching the experiences of counseling graduate students with chronic mental illness offers potential for significant insights. It can reveal the unique challenges these students face, informing the development of support mechanisms and interventions tailored to this group.

Future research should continue to explore the use of IPA in counselor education, particularly in relation to marginalized or under-researched groups. Further work could also focus on refining the IPA methodology, to enhance the rigor and transparency of the analysis process.

Theoretical Framework

Bandura's Self-Efficacy Theory (1977) has been a topic of considerable interest in psychology, though not yet applied in current research to the population of counseling graduate students experiencing CMI. This theory posits that an individual's belief in their ability to execute behaviors necessary to produce specific performance attainments affects their feelings, thoughts, motivations, and behaviors. In the realm of counseling psychology, self-efficacy has been linked to mental health outcomes and the therapeutic process. Self-Efficacy Theory offers a valuable framework for understanding and supporting graduate students in counseling programs with CMI.

Bandura (1977) defined self-efficacy as “People’s judgments of their capabilities to organize and execute courses of action required to attain designated types of performances” (p. 191). Bandura wrote that the foundation of self-efficacy is belief in one’s capabilities to influence an outcome. This theory suggests that individuals derive information to assess their efficacy beliefs from four main sources: enactive mastery experiences, vicarious experiences, forms of persuasion, and physiological and affective states (Bandura, 1986).

According to Bandura (1977), enactive mastery experiences or actual performances provide the most authentic evidence of personal mastery, hence significantly influencing self-efficacy beliefs. For counseling students with chronic mental illness, successfully navigating through academic tasks could increase their faith in their abilities, positively impacting their sense of self-efficacy (Usher & Pajares, 2008). Vicarious experiences (observing others' actions and their consequences), serve as another significant source of efficacy information (Bandura, 1986). In an academic setting, students with chronic mental illness might watch their peers who face similar challenges successfully complete tasks, thus enhancing their own self-efficacy beliefs (Schunk & Hanson, 1989). Forms of persuasion, verbal or otherwise, also could help shape one's self-efficacy. Encouragement from professors, peers, and therapists could reinforce these students' beliefs in their capabilities, while negative feedback could potentially undermine them (Zimmerman, 2000). Lastly, physiological and affective states are significant as individuals often interpret stressful reactions and tensions as signs of vulnerability to poor performance.

In some instances, students might hear feedback intended to be developmental and helpful as overly harsh or personalized when they are affectively in hyper-arousal. This misinterpretation can negatively impact their self-efficacy, as they may feel criticized rather than supported in their growth and development. Some more hypothetical examples of how CMI may negatively impact self-efficacy:

1. A student with PTSD might be triggered by certain situations or topics covered in their counseling coursework or during clinical practice. This could lead to hyperarousal,

during which they may perceive feedback as threatening or overly critical, reducing their self-efficacy.

2. Obsessive-Compulsive Disorder (OCD) and Perfectionism: A student with OCD might strive for perfection in their academic work and counseling skills. When they receive constructive feedback, they may interpret it as a sign of failure or weakness, leading to a decrease in self-efficacy.
3. Eating Disorders and Body Image Issues: A student dealing with an eating disorder might have low self-esteem, particularly related to body image. If they perceive any feedback as a personal attack, even if it's related to their counseling skills, this could trigger hyperarousal and further lower their self-efficacy.
4. Borderline Personality Disorder (BPD) and Emotional Instability: A student with BPD may experience emotional instability, which could lead to misinterpretation of feedback. They might see neutral or positive feedback as negative or personalized, causing them to either argue with the feedback (hyperaroused response) or completely shut down (hypoaroused response), neither of which allow them to use the feedback constructively.
5. ADHD and Difficulty Focusing: A student with ADHD might find it challenging to focus during feedback sessions. This could lead to missing important details or misinterpreting the feedback, which can negatively affect their self-efficacy.

For students with chronic mental illness, understanding and interpreting these physiological states correctly could help them manage their illness and bolster their self-efficacy (Bandura, 1997). Failure to do so could lead to dysregulation, most commonly reflected in either a hyperaroused response of arguing with the feedback or a hypoaroused shut down to the feedback. In neither situation is the individual able to use the feedback in a helpful manner.

Researchers have shed some light on the role of self-efficacy in the counseling profession. One study found that various factors can influence the self-efficacy of counseling students, including the quality of their training and supervision (Larson et al., 2004). This study underscores the importance of providing high-quality education and supervision to enhance students' self-efficacy. Multicultural counseling competence and self-efficacy have also been examined. A moderate relationship was found between self-reported multicultural counseling competence and self-efficacy, suggesting that education can influence these elements for counseling graduate students (Barden & Greene, 2015). Performance feedback has been found to significantly impact counseling self-efficacy and counselor anxiety, with positive feedback improving self-efficacy and reducing anxiety (Daniels & Larson, 2001).

While many of these studies connected self-efficacy and academic outcomes among counseling graduate students, none fully explore the mechanisms through which self-efficacy influences these outcomes. For example, it remains unclear whether self-efficacy directly impacts academic performance or indirectly influences it through factors such as coping strategies or motivation. Understanding these underlying processes, through the experiential lens of a qualitative study, could provide valuable insights for designing effective interventions for developing more positive self-efficacy for graduate counseling students with CMI.

Overall, however, research on interventions aimed at improving self-efficacy in this population is limited. This creates a need for additional research to investigate the effectiveness of such interventions. Further, the impact of self-efficacy beliefs on clinical practice outcomes among counseling graduate students with CMI remains underexplored.

Chapter 3: Methodology

Overview

This chapter will describe the methodology that was used to conduct a phenomenological study of counseling graduate students with a chronic mental illness, toward an end goal of better understanding their lived experiences and what types of support might be most warranted. Specifically, the research design, participants, data collection methods, data analysis techniques, ethical considerations, and limitations will be discussed.

Research Questions

The following research questions have been developed to better understand the lives experiences of counseling students who live with a CMI. The primary research question, consistent with phenomenological inquiry, is:

1. What is the lived experience of counseling students who live with a CMI?

From this, two sub-questions of interest will also be considered:

a. What kind of role does/did stigma or self-stigma play in your experience?
b. What has been/was the experience of disclosure or non-disclosure of CMI within a counseling program and why?

Research Design

The research design for this study is Interpretive Phenomenological Analysis (IPA). IPA is particularly well-suited for exploring subjective experiences (Creswell, 2013), and the aim of this study was to gain insight into the experiences of counseling graduate students with chronic mental illness. This approach is based on the philosophical concept of phenomenology, which involves examining how people experience and understand their world (Giorgi, 2009; Merleau-

Ponty, 2012). Phenomenology is an approach to qualitative research that focuses on the lived experiences of the participants and aims to uncover the meanings that participants ascribe to their experiences (Creswell, 2013).

In a phenomenological qualitative study, the researcher typically conducts in-depth interviews with participants who have experienced a specific phenomenon. The researcher also may use other data collection methods, such as observational techniques and document analysis, to gain a more complete understanding of the participants' experiences (Creswell, 2013; Moustakas, 1994). For this study, semi-structured interviews will be conducted with participants. Semi-structured interviews will be used to allow for reasonable consistency across participants while also allowing the research some flexibility in the dialogue. Once the data has been collected, the researcher engages in a process of data analysis to identify the essential themes and patterns that emerge from the data. This process involves bracketing, which means setting aside the researcher's preconceptions and biases to approach the data with an open mind (Giorgi, 2009). Through this process, the researcher aims to uncover the essential structure and meaning of the participants' experiences.

Phenomenological qualitative research requires the researcher to approach the data with an open mind, without imposing any preconceived categories or frameworks onto the data. The goal is to identify the essential themes and patterns that emerge from the data and to describe the essence of the phenomenon being studied (Creswell, 2013; Polkinghorne, 1989). To ensure the rigor and trustworthiness of the research, phenomenological researchers often use strategies such as member checking, peer debriefing, and keeping a reflective journal to document their own biases and assumptions (Creswell, 2013). These strategies help to ensure that the research is credible and that the findings accurately reflect the experiences of the participants. Generally, no a priori assumptions or predetermined theory is considered in the data analysis. Because the requirements for this dissertation include a theoretical framework, however, the theory introduced in Chapter 1 and explored more fully in Chapter 2 will not be used for data analysis in Chapter 4, but will be reexamined in Chapter 5 to consider how the findings do and do not fit within this framework.

Participants

Participants for this study were 8 students living with a diagnosis of a CMI who were currently enrolled in a counseling program (7) or who had graduated within the past three years (1). Specifically, participants were required to meet the following inclusion criteria:

- Be at least 18 years of age;
- Have a chronic mental illness, such as but not limited to - depression, anxiety, BPD, bipolar disorder, or schizophrenia
- Be willing to interview at least one time
- Agree to being audio recorded
- Have completed at least one semester of clinical fieldwork

Purposive sampling was used. This means selectively choosing individuals who can provide rich, detailed insights into their lived experiences. The risk here is possible bias in participant selection but having clear criteria for participant selection within each stratum can help mitigate this. Purposive sampling involved selecting participants who were most likely to provide rich and meaningful data (Creswell, 2013).

Additionally, because intersecting identities may be relevant, a minimum of three of the eight participants who were included had at least one marginalized identity based either on race/ethnicity. This researcher acknowledges that many, many more identities are present within this population, but is contained by the limits of a dissertation. Although this is not inclusive of all possible marginalized identities, this focus seems important to clearly delineate participants. This number is not chosen randomly. According to CACREP's 2022 Vital Statistics Report, White students make up 56% of CACREP master's programs, with non-white students roughly 35%, and 10% unknown or other. Accordingly, three of eight participants is 38%, roughly corresponding to national norms.

Recruiting participants for a qualitative study on graduate counseling students was challenging, particularly when seeking participants outside of an immediate student body. One approach was to use social media platforms such as Instagram and LinkedIn to advertise the study and recruit participants. These platforms provided a convenient way to reach potential participants and created a large pool of participants (Stieglitz, Bazarova, & Brewer, 2019). Additionally, online counseling forums and communities, using the American Counseling Association's (ACA) counseling committees' sub-pages and discussion boards were used to recruit potential participants who may not be active on social media.

Additionally, counseling programs accredited by CACREP were contacted requesting permission to recruit their students for the study. Specifically, faculty liaisons were contacted with a written request that they share information about the study with their students (Petr, Musil, & Vašutová, 2017) (See Appendix_A). Inclusion criteria were important to ensure homogeneity around critical aspects of the study. All participants were provided consent forms, procedures, risks, confidentiality, the voluntary nature of the study, how to withdraw from it, and contact information.

The recruitment process was ongoing until data saturation was reached which is when new data no longer provided significant insights into the phenomenon being studied (Guest, Bunce, & Johnson, 2006). This was expected to occur within the 8-12 participant range, and the principal researcher and the auditor determined this to be the case with 8 participants. Data saturation is a key component of phenomenological research, which seeks to capture the essence of a phenomenon as experienced by participants (Moustakas, 1994). To ensure data saturation was reached, the researcher employed a purposive sampling technique, seeking participants who represented a range of experiences with chronic mental illness (Creswell, 2014). Clarke (2010) stipulated that three is the default sample size for undergraduate or Masters-level IPA study, whereas 4-10 is advised for professional doctorates. The sampling for this researcher continued until the researcher collected data from 8 participants.

As the analysis progressed, the researcher continually reviewed the data and compared it to the emerging themes and patterns to determine if data saturation had been reached (Guest et al., 2006). When data saturation was not been reached, the researcher continued to recruit additional participants until no new insights are gained from the data (Creswell, 2014). It is important to note that data saturation is not a binary process, but rather a subjective judgment based on the researcher's interpretation of the data (Charmaz, 2006). Therefore, the researcher documented their decision-making process and provide a rationale for determining when data saturation was reached. This documentation is included in the findings chapter to ensure the transparency of the research process.

As Chapter 2 demonstrated, intersectionality within research designs on this topic has been either underreported or overlooked. Given the potential diversity of experiences, influenced by factors such as race, gender, sexuality, and type of mental illness, a combination of stratified and purposive sampling techniques might be considered optimal for this research, with large groups stratified. However, due to the truncated timeframe of a dissertation study, and the anticipated difficulty of finding participants willing to discuss a sensitive topic, this study focused focus on finding participants that fit the listed criteria.

Procedures

Once IRB approval was attained, recruitment began using the aforementioned strategies. Informed consent (See Appendix B) was attained prior to data collection, and occurred via interviews and signed electronically via Docu-Sign. All interviews were conducted remotely using a HIPAA compliant online platform. All interviews were recorded and transcribed, and the deleted upon transcription.

Interview Protocol

After indicating interest in the study, potential participants were screened for their suitability for the study. Included in that was be a series of demographic questions (See Appendix C), including:

1. Status of enrollment at time of interview (currently enrolled; graduate; did not finish)
2. What is your diagnosis/es of CMI?
3. What is your counseling specific track?
4. What is your ethnic or cultural identity?
5. What is your racial identity?
6. What is your gender identity?
7. What is your sexual orientation or identity?

After e-signing an informed consent, participants who met inclusion criteria were interviewed. The interviews were conducted online, in encrypted Zoom calls, and lasted an average of 59 minutes. The interviews were semi-structured, meaning that a set of open-ended questions was be used as a guide (See Appendix F), but the interviewer was free to ask follow-up questions and explore topics in greater depth as they arise (Creswell, 2013). The interviews were audio-recorded and transcribed verbatim.

Data Collection

The purpose of research questions in a qualitative research study is to guide the researcher in exploring and understanding a particular phenomenon or experience. According to Creswell (2014), the research questions in a qualitative study are designed to elicit rich, detailed, and in-depth information about the participants' experiences and perspectives. The research questions in a qualitative study are typically open-ended and exploratory, and they are intended to generate data that can be analyzed and interpreted to gain insights into the phenomenon under investigation. The three larger questions that guided the interviews are:

1. What is the lived experience of counseling students who live with a CMI?

From this, two sub-questions of interest were also considered:

1. What kind of role does/did stigma or self-stigma play in your experience?
2. What has been/was the experience of disclosure or non-disclosure of CMI within a counseling program and why?

The full interview protocol can be found in Appendix C.

Data Analysis

Data analysis for this study was conducted using a thematic analysis approach. This involves a systematic process of identifying, analyzing, and reporting patterns or themes within the data (Braun & Clarke, 2006). The data was then analyzed using an iterative process of coding, categorizing, and identifying themes. This was done first by the primary researcher and then. confirmed by a second researcher (a doctoral peer in Counselor Education and Supervision) to enhance the validity and reliability of the findings (Creswell, 2013).

Trustworthiness

To ensure the trustworthiness of the study, several strategies were employed. Member checking was used to validate the accuracy of the data and interpretation of the results (Creswell, 2013). Participants were given the opportunity to review the findings (they were sent encrypted emails containing password protected copies of the transcribed interviews) and provided feedback or clarity. In addition, debriefing was used to provide an external perspective on the data analysis process and interpretation of the results (Elliott & Timulak, 2016). This debriefing included conferring with dissertation chair in order to examine possible counter-transference or bias, as well as with a doctoral colleague. Finally, the researcher engaged in reflexivity throughout the study, via a journal, which involved reflecting on their own biases and assumptions and how they might have shown up to influence the research process (Creswell, 2013).

Ethical Considerations

In conducting research with participants who have chronic mental illness, it was important to consider a number of ethical concerns. This section will address key ethical considerations that were taken into account in the planning and implementation of this study. No data will be collected nor participants recruited until this study was approved by the William and Mary Institutional Review Board.

Informed Consent

One of the most important ethical considerations in research with individuals who have chronic mental illness is obtaining informed consent (Barker, 2014). Participants must have a clear understanding of what they are agreeing to and must provide consent voluntarily. In this study, informed consent was obtained from all participants prior to their participation, and include information about the purpose of the study, their role in the study, potential benefits and risks, confidentiality and anonymity, and their right to withdraw at any time (Elliott & Timulak, 2016). The informed consent document (See Appendix D) was written with the intention of being clear and concise about expectations.

Confidentiality and Anonymity

Confidentiality and anonymity also are important ethical considerations in research with individuals who have chronic mental illness. Participants may be reluctant to share personal information due to concerns about stigma or discrimination (Barker, 2014). To ensure confidentiality, the data collected in this study was de-identified, and pseudonyms were used to protect participants' identities (Elliott & Timulak, 2016). In addition, the data was stored securely and only accessed by the research team.

Potential for Harm

Given the sensitive nature of the research topic, there is a risk that participants could have experienced harm or distress because of their participation in the study. The researcher made every effort to minimize the risk of harm, including conducting the study in a supportive and non-judgmental environment, and allowing participants to withdraw from the study at any time (Barker, 2014). In addition, all participants were given referrals to online resources for counseling and mental health support after the interview was completed (See Appendix E).

Assumptions, Delimitations, and Limitations

Assumptions

The assumption was made that the participants in the study are truthful and accurate in their self-reported experiences of living with chronic mental illness. According to Charmaz (2006), phenomenological research relies on the lived experiences of the participants to reveal the essence of the phenomenon being studied. Another assumption is that I had to combine data from current students as well as a recent graduate, and must acknowledge that the experiences students may have had varied based on the pandemic and how course delivery was affected.

Delimitations

The study was limited to graduate counseling students in CACREP accredited master's programs and recent graduates of CACREP accredited programs, which may have limited the generalizability of the findings to other populations within counseling programs, including doctoral students and those enrolled in non-accredited programs. This is a common limitation of qualitative research, which is often based on small, non-random samples (Creswell, 2014). Additionally, the study was limited to participants who were willing and able to participate, which could be a limitation on two fronts. First, it is unknown how participants who chose to participate may differ in some systematic way from those who do not, limiting the transferability of findings to the broader population. Second, the online data collection process may have excluded individuals who did not have access to a computer or who are uncomfortable with participating in online research. However, online recruitment has been found to be an effective way to reach a diverse range of participants (Birnbaum et al., 2017). Further, given that potential participants were current graduate students or a recent graduate of graduate programs, it was anticipated that the online recruitment and interviewing processes would not compromise the external validity of findings from this study. Finally, this study was focused specifically on the experiences of counseling graduate students with CMI. It did not explore the experiences of individuals with other mental health conditions or individuals with CMI who are not graduate counseling students.

Limitations

A possible limitation is that the responses of this sample of participants may or may not be transferable to the larger population of counseling graduate students with chronic mental illness. This study recognizes that it is not possible to include every possible participant, and therefore may not be able to have captured the full range of experiences of counseling graduate students with chronic mental illness.

Another limitation of this study is the potential for social desirability bias in participant responses. According to Shenton (2004), participants may feel pressure to provide socially desirable responses to avoid negative evaluation, which could impact the accuracy of the data collected. Another limitation is the potential for researcher bias in data analysis. Phenomenological research relies on the interpretation of the researcher, which can introduce potential biases in the data analysis process (Giorgi, 2009). It is important to acknowledge the potential for researcher bias in qualitative research, especially when the researcher has a personal or professional interest in the topic being studied. To minimize the risk of bias, the researcher employed a reflexive approach, which involved reflecting on their own beliefs and assumptions and how they might have influenced the research process (Creswell, 2013). In addition, a second researcher was engaged in in the coding and analysis process to help provide an alternative perspective and increase the rigor of the study, as well as provide a second opinion on saturation.

Chapter 4: Results

Introduction

The purpose of this study was to understand the lived experiences of graduate counseling students diagnosed with chronic mental illness (CMI), using Interpretive Phenomenological Analysis (IPA). Specifically, this study was designed to begin the process of collecting information that better informs further work regarding students who managed chronic mental illness, particularly including the role of stigma and the impact of disclosure of CMI. Using IPA, I examined participants' recollection of experiences and worked to uncover the meanings that participants ascribed to their experiences (Creswell, 2013).

I interviewed eight participants to obtain a thick description and identify recurring themes across their experiences. Through detailed and systematic data collection and analysis, meanings emerged to answer the main research questions and two sub-questions. This chapter provides descriptions of the participants, data analysis, and examines the emergent themes.

Participant Information

The eight participants were comprised of current graduate counseling students (7) or recently graduated (1) who had been diagnosed with at least one chronic mental illness (CMI) and had completed at least one semester of fieldwork. Data saturation was considered complete with 8 participants as no new emergent themes were emerging. Participants varied in gender identity, sexual orientation, ethnicity, and the specific types and numbers of CMI they managed. These diverse backgrounds contributed to a rich array of experiences and perspectives, which are essential for a comprehensive understanding of the phenomena under study. The participants were representative of two counseling graduate tracks- Clinical Mental Health Counseling and Marriage and Family.

The most represented diagnosis was Generalized Anxiety Disorder (4), followed by ADHD (3) and PTSD (3); Anorexia Nervosa (2) and Panic Disorder (2); and then OCD (1), Borderline Personality Disorder (1), Bipolar Disorder (1), and Schizoaffective, Bipolar Type (1). The average participant had two co-occurring mental illness diagnoses, whereas two participants had four diagnoses, five participants had two diagnoses, and one participant had one diagnosis (see Table 1).

Table 1 Demographics

Participant	Gender Identity	Orientation	Ethnicity/ Race	Quantity of Diagnoses
Participant #1	cis female	bisexual	white	4
anxiety disorder panic disorder ADHD PTSD				
Participant #2	cis female	heterosexual	white	4
anxiety disorder anorexia nervosa PTSD depression				
Participant #3	demi-woman	queer	east Asian	2
anxiety disorder panic disorder				
Participant #4	cis female	queer	white	2
anorexia nervosa OCD				
Participant #5	non-binary	queer	biracial	2
schizoaffective bipolar type PTSD				
Participant #6	non-binary	queer	biracial	2
bipolar borderline				
Participant #7	cis female	bisexual	white	2
ADHD anxiety disorder				
Participant #8	cis female	heterosexual	white	1
ADHD				

Each participant description was obtained from the demographic information each student provided during the initial screening questionnaire, with any additional information brought up by participant during the course of the interview if they thought it pursuant to the questions asked. Pseudonyms are used to protect the identities of participants.

Trinity

Trinity was a 30-year-old clinical mental health counselor who graduated 1 year prior to data collection. Trinity described herself as “white, cisgender, bisexual, agnostic” and had diagnoses of ADHD, PTSD, Generalized Anxiety Disorder, and Panic Disorder.

Hannah

Hannah was a 27-year-old who had completed one semester of fieldwork. Hannah described herself as “white, queer, cis-woman” and had diagnoses of Obsessive Compulsive Disorder and Anorexia Nervosa, atypical.

Klay

Klay was in their upper 20s and had completed 2 semesters of fieldwork as a clinical mental health counseling student. Klay described their identities as “Asian, queer, demi-woman, and non-citizen” and had diagnoses of Anxiety Disorder and Panic Disorder.

River

River identified as a member of Gen Z, and was in their final semester of a clinical mental health counseling program. River described themselves as “non-binary, Biracial, black/white, white-passing” and had diagnoses of Schizoaffective Disorder Bipolar Type and PTSD

Alice

Alice was in her mid-20s and a marriage and family counseling student who had completed 2 semesters of fieldwork, and identified as a member of Gen Z. Alice described herself as “white, cisgender, heterosexual, high SES, and physically disabled” and had diagnoses of PTSD, Depression, Anxiety, and Anorexia Nervosa.

Ada

Ada was a 24-year-old clinical mental health counseling student who had completed 1 semester of fieldwork. Ada described herself as “cisgendered female, bisexual, interdenominational Christian” and had diagnoses of ADHD and generalized anxiety disorder.

Cameron

Cameron was a 22-year-old clinical mental counseling student who had completed a semester of fieldwork. Cameron described herself as “white, cisgender, straight” and had a diagnosis of ADHD.

Elliot

Elliot was a 27-year-old marriage and family counseling student who had completed two semesters of fieldwork. They described themselves as “non-binary, femme-presenting, and mixed ethnicity” and had diagnoses of Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder and Borderline Personality Disorder

Research Question

The primary research question asked, “what is the lived experience of counseling students who live with a CMI?”. Participants reported a variety of experiences as counseling graduate students managing a diagnosis/diagnoses of a chronic mental illness, though general themes did emerge, including chronic mental illness as a strength; the importance of outside support systems; a desire to be known; and daily management.

CMI as a Strength

Participants largely agreed that their experiences with CMI makes them strong counselors, due to increased empathy and experiences around working with medical and clinical systems. Klay noted that their experiences with managing severe anxiety had given them perceived strength of skill when it comes to working with clients.

> I'm super sensitive to nonverbal cues in session, especially related to anxiety because I did that myself. So, I would try to notice their nonverbal cues. Like if they're like scratching their hair or doing, doing this or like just looked uneasy. Like I would pause and I would say, well I noticed X, Y, Z how did you, I want, I wonder, how are you feeling right now here with me? Do you wanna pause? Do you want me to, to slow down a bit? Like. how how can I be more helpful to you? How can I make you feel more safe? So I'm sensitive to that. And also…so when my clients ask me for coping skills for anxiety, I am kind of like an expert it. Again, like I can offer them my own coping skills offer them like my own thoughts about it. I feel like these are real strengths that come from living with anxiety.

Trinity also connected her experiences with panic attacks and choosing to go on medication as a strength for her when working with clients.

> I think it's a, a really overall helpful perspective. Um, because when I've had clients talk about like, you know, I can't breathe and I'm having these feelings, and they came into my office having a panic attack and they couldn't name it. You know, getting to literally sit next to them and kind of just do that, like emotional regulation, we're just gonna breathe and bring you down and then we can talk about it. Knowing what it was like on the other side of that, I think was really helpful for me as a counselor… I would have

> clients who are interested in getting on antidepressants. And so I could talk to them both from the counselor perspective of things and sometimes from my own perspective, of course, navigating when that disclosure is helpful and when it's not. But they'd be come in and be like, yeah, I'm gonna start on Lexapro, and I'm like, high five, Lexapro gang, you know? And that also kind of helped build some rapport too. It's, you know, like the only difference is I'm sitting on this side of the desk and this chair and you're sitting on that chair.

Hannah cited her experiences battling stigma within the mental health and medical community to have her eating disorder recognized (her BMI was never as low as the DSM required, though her behaviors were damaging) as giving her added insight to the frustration and hurt that clients can encounter when seeking support. She also said her experiences growing up with diet culture help her to see more clearly how that can impact current psychological and clinical treatment,

> I think having an experience of my own eating disorder and what it's like in the extreme, the diet culture influence that like our entire society and also still psychology and clinical treatment has, it has been really helpful. I'm still like pretty early in my career, but, um, I think that absolutely gives me an advantage with that population because I have my own like firsthand understanding of how hard it is to deal with that and how much, how many like obstacles there are to like overcoming the struggles of an eating disorder, even just getting it diagnosed correctly. Um, so I think that's definitely helped me as far as like how to approach that in clinical work.

Outside Support Systems

Every participant mentioned that they had a strong outside support system, and that this was a main source of how they managed their diagnosis/diagnoses. Some mentioned that having this significant outside support system made them less likely to disclose to their faculty or peers. For example, Trinity said that having an outside support system made disclosing seem less necessary and that these support systems were present for her in ways the program did not know how to be in the wake of a mass shooting that happened at the high school Trinity had attended.

> I had a really good support network in my friends. I had friends not in the program. And a lot of encouragement in that, you know, most of the people around me could clearly see like, this is where I was supposed to be. Um, and that was really helpful. Um, animals, I was going over to friends' houses at any given moment to be like, can I borrow your dog and take your dog for a walk? I was volunteering at the animal shelter. I mean, volunteering is a loose term. I would pretty much just go there and like lay in the puppy room or climb into one of the kennels and hang out with someone. After the shooting, all I wanted to do was regulate next to animals.

River said that their support system was critical to their ability to maintain their work in their counseling program.

> Surrounding myself with people who do accept me…I do have a few select people who I know support me and would, uh, love and accept me no matter what, and having their support. And there are reminders that I'm able to do this. Um, I think social support is huge with the, this sort of stuff.. I don't know how I'd be able to continue going if I didn't have the people that I have who do accept me to counter the other negative comments that I hear…often in my own program.

Hannah’s support systems were her outside clinical group and non-program friends.

> I've been in group therapy, like specifically like eating disorder themed group therapy for about two years and that's been like huge in my recovery and like being able to manage like the stress of grad school and not like slip back into like my sick body or like my, um, bad coping habits. I think that group like where I have a space to like, uh, like learn about like anti-diet culture beliefs and like be in a space where everyone like understands my experience has been like really important. I could talk out being uncomfortable in classes or with DSM heavy discussions. I think also just like kind of in the same vein, but like talking with friends I used to dance with in the ballet world and like sort of bonding over our shared experience of like, yeah, like we have all these feelings and the ones I talked to aren't dancers anymore either. So it's kind of just like going through this transition period together and feeling like, oh, I'm not alone and like having these thoughts and like other people think this too has been really helpful. I can’t have these conversations at school, with any depth, or without people getting weird about it, so having some support from people going through it also has been really nice.

Desire to Be Known

All eight participants articulated that they harbored a desire to share their diagnoses with their program, peers, and faculty. Participants stated various reasons for doing so, with some noting experiencing dissonance from programs asking them to “…show up as their authentic selves,” (River), “…be their whole selves” (Ada) “…share deep reflections” (Trinity) and not knowing how to broach their diagnoses as part of those asks. Others shared that they often felt like it would be a positive for them to be able to share so that peers and faculty to take into account some of the language used (this was particularly important for the students with

Anorexia, who both shared experiences of food-centric language in ice-breakers). Hannah said that

> I think it would be nice if I could like sort of anonymously like tell my professors like, can we not talk about food and body in class? 'cause like there will be times, in classes like an icebreaker, like what's your favorite snack? Or something like that, which can be like really kind of triggering for me. And like in instances like that, it's kind of hard for me to stand up and be like, well actually can you not talk about that because I really don't want to. So yeah, I guess I do wish that like there was like an anonymous way I could disclose that without having to be like, 'can I talk to you? I have eating disorder and I can't talk about that.' When programs ask us if there are things they should know, I wish there was an easier way to have this out there that didn't seem so exhausting to me.,

River, who had not disclosed any diagnosis with any of their program, said that they had frequently longed to share more of themselves.

> … If I had faculty and supervisors who allowed me to talk about it and were fully accepting, I think it would definitely have such a positive effect on my mental health and my symptoms. Like I said, like me and my therapist identified that stigma… worsens my symptoms when I know that when I'm like not really believing my ability because of a comment I heard or experience I had….that was like really affected. Like the way that I saw myself or like unlike another wake up call of like, oh, this is how people would see me. That's when I, my stress heightens and I'm like, oh my. Like, and then my symptoms heighten and like it's all outta whack and then I have to recuperate. So if I lived in a world and if I worked at a place and if I went to school at a place where this was fully accepted and I was able to talk about it without people applying stigma to it or, you

> know, seeing me differently, like, I think I would actually like fully thrive to be able to exist like as I am.

Daily Impact

Despite the overall spectrum of experiences, a recurring theme was that each participant was extremely mindful and aware of their diagnosis/diagnoses as it pertained to their experiences as a graduate student, and each reported engaging daily with their management or coping strategies. Over half cited physical activity as a major component of their management of their CMI symptoms.

Alice reported that her coping strategies have been years in the making but that they are critical to her management.

> Exercise is the big one for me. I have a Peloton bike in my apartment. And that has been an absolute game changer because don't always have time or the money or the motivation to come home, get dressed, put shoes on, and then drive back to the gym. But my bike is in my living room, so I just come home, I put my bike shorts on and I clip in and I'm done. So that's been, that's been the biggest game changer…having the walking desk here has also been incredibly helpful as a coping mechanism because if I have a day where I've got hours and hours worth of assignments that I'm staring down the barrel at, time flies a little bit aster when you put the computer on the walking desk and I'm walking while I'm doing it. And then I'm not sitting sedentary all day. And it also helps with the chronic pain, which is a bonus, because then that doesn't spiral in a mental health crisis.

Cameron described using a combination of a strict routine of scheduling and exercise to help manage her ADHD so that she does not have to resort to coping strategies.

> I've definitely relied heavily on scheduling and just routine based, like daily living practices. Um, 'cause once I get out of whack with really any of it, like, it's like a domino effect. Like everything kind of just goes to. I guess I try to implement all of that to avoid having to do coping or like anything on the backend before things get too bad. But, definitely sitting and doing a detailed outline of my schedule for the week. I literally will do it hourly so that, I can see where there are gaps, 'cause there are gaps, you know, I can't be doing things all the time, and so I'll try to find other little mindfulness practices to implement in those windows. I feel like journaling has been something that's been very good for me just to kind of, if I'm hyper fixating on any thoughts or assignments, things that are coming up, I can sit and write about it and that makes me feel better. And I won't sit in that loop for so long. Exercising is definitely something that helps put my physical and mental energy towards something positive for myself. That's also I'm still thinking about all of the things I have coming up, but at least I will tire myself out a little. So I can't think about it as hard. I've gotten pretty decent at managing it [ADHD] with all of the things on top of school.

Ada share that they split management into two tiers; a larger strategy for outside of school, and for managing symptoms during class or sessions.

> Exercise is huge for me. Huge, huge, huge. Um, specifically like running because it helps me, like I go on emotional runs. I'll go on an angry run or a sad girl run, and that really helps me, like all of the emotion and the mental illness that I'm holding in my body. It's an outlet for that. Then on a micro level, I always try to make sure I have either a sparkling water or an ice cold water. So if I'm in lab or lecture and I'm starting to get

> really anxious, I can drink some of that really cold water and shock myself back into a regulated state.

Subquestion 1

What kind of role does/did stigma or self-stigma play in your experience?

This question, and its corresponding interview questions, appeared to open participants up to more critically examine how they made decisions around disclosure, particularly as it related to self-stigma and how that weighed into their decision making around help-seeking and disclosure.

Fear of Judgement

While most (6) reported not feeling or experiencing explicit stigma from their program, every participant reported some level of fear of judgement from peers. One student, River, reported extremely negative experiences with stigma and discriminatory language around their diagnosis, from both peers and professor, during a supervision session, and referenced this experience directly as to why they did not disclose their schizoaffective diagnosis. While River stated that over the course of their program they:

> …wished I could trust them [peers/faculty] and I wish that I could receive the response that I really need to make me feel like I belong in this field with them…" they felt unable to do so after hearing perceptions and attitudes towards people on the schizo spectrum. During this supervision session, "…a peer had a client with a schizo spectrum disorder. And I felt like that discussion was very stigmatizing. It felt like everybody immediately did not trust this client, um, did not trust their experiences, did not trust their feelings, did

> not trust, you know, not even like their trauma, they're doubting, like that person actually went through that traumatic experience. And the professor was sort of encouraging these comments. And in that moment I was like, thank God, thank God I didn't say anything. Like, here it is like evidence again that if I would've said something who knows what, you know, how people would've seen me.

Self-Stigma

Seven participants reported high levels of self-stigma and negative internalized beliefs regarding their diagnoses and their abilities to be effective counseling students and future counselors. All seven of these participants linked these beliefs to their decisions of to whom and when they chose to disclose.

Cameron shared that they have not formally disclosed to their program or sought accommodations for their diagnosis of ADHD, and linked that directly to some self-stigma they carry around their diagnosis.

> I've kept things informal and that's another, it's my final layer of growth to achieve, I guess. I feel like I have to shed of the guilt and shame around ADHD. I haven't made plans around formal accommodation from our Office of Disability Services only because I've, and I mean, I don't know how good or bad this is, but I really do try my hardest to perform on par with my neurotypical peers for as, like, far as I can push myself. I am not a fan of the people that take advantage of accommodations. I don't want to be seen as someone doing so, even though it's unlikely that it would be viewed that way. I don't want them to see my ADHD as being like a handicap or something that that makes me lesser just because I think that there is a lot of stigma and minimization of sort of how dysregulated ADHD can make you and your life, especially if you're unmedicated.

Minimizing Diagnosis

The students with diagnoses of ADHD and Anxiety Disorders reported a more constant consciousness of being judged for their diagnoses than students with more traditionally stigmatized CMI, such as bipolar, anorexia, and schizoaffective. Within this subgroup (ADHD and/or Anxiety diagnoses) was a recurring theme of downplaying the impact of their diagnoses and what others might think if they disclosed them, a sense that these diagnoses, as Cameron put it, “weren’t a big deal, and if I can’t function with ADHD, not even a really hard one [diagnosis], people will think I am weak.” Similarly, Trinity shared that “ I am fortunate to I guess, have that kind of privilege of my diagnoses [anxiety, panic disorder, ADHD, PTSD]. Like these are not ones that typically raises alarms, um, but I think there's always the risk of that, like disclosing, Hey, I'm experiencing this or I have this diagnosis. You know, who could look at that the wrong way?”.

Perceived stigma around anxiety diagnoses and the impact of that shaped Klay’s fieldwork trajectory, and shifted their work from in-patient to less intensive outpatient. Klay, who manages severe anxiety, reported an interaction with a supervisor (who Klay had disclosed to) that left them reeling and doubting their abilities as counselor due to their diagnosis:

> I told her I cannot take one more suicidal client right now because I didn't feel very mentally good for it. Like, I'm on a heavy caseload and I'm dealing with difficult ones right now. I need my own time. Can I not take this one? And she was being very forceful on that one. And she was like can choose however, like, however many you wanna take, but just consider your hours, consider your graduation. I mean you have like, you feel anxious, but, but people also feel anxious too. You're not the only one. Just consider that as a challenge to yourself. Just push yourself harder. She just said like so much hard

> harsh stuff and I was like, Hmm. That didn't feel good. But I did not blow up with her because she's my supervisor, so yeah. I feel like she was saying I wasn't competent to work with my caseload or to work with suicidal ideation or whatever. I feel like she was saying that I got anxiety so I could not show up fully at my job. I mean, that might not be what she meant, but that was how, how I felt about what she said. That was probably the only time I felt stigmatized during my work, though at the time that is not what I would have called it.

Motivator for Career/Intended Client Population

Participants reported that stigma around mental illnesses were a driver in pursuing a career as a counselor in general, as well as even more specifically for populations with whom they share a diagnosis. Some participants recognized this to be a motivator prior to enrolling in a counseling program, while others discerned this as they moved through experiences while in their counseling programs

River shared that first they were interested in becoming a counselor because they “were always told I was a good listener”; but as their experience with CMI and as a counseling student deepened,

> …the meaning I was making out of it changed, um, as I began to realize like a lot of the systemic issues within this field, and a lot of personal experiences, uh, with those issues specifically surrounding like, uh, persistent and serious mental illnesses…and then I also have a couple family members, some friends, who also struggle with diagnoses that are very stigmatized like mine [schizoaffective]. So I feel like as I continued on, I became a lot more passionate about being a mental health clinician who showed up for clients experiencing the same stigma and doing what I can within the system to provide them an

> experience where they felt more humanized, and not so de-dehumanized as this field sort of does.

Alice voiced another perspective on how her experiences with CMI have influenced which population she most wants to work with, which had less to do with how her program addressed this population and more around her comfort and ability to empathize with this group:

> The population that I am most interested in working with is people who deal with complex PTSD. Um, and there's obviously like a lot of suicidality that comes from that. And I'm a suicide survivor myself. Um, and I think it gives me a unique perspective in clinical work when I'm working with suicidal patients because I've been there before… I've been in that head space and can understand it. And I do think that that gives me, you know, like just the unique ability to understand my patients in that specific scenario on a deeper level.

Subquestion 2

What has been/was the experience of disclosure or non-disclosure of CMI within a counseling program and why?

In the following section, I will explore the varied experiences of the eight participants concerning the disclosure or non-disclosure of Chronic Mental Illness (CMI) within their counseling programs. The analysis will reveal individual's decision-making processes around disclosure, the factors affecting these decisions, and the consequences and outcomes of these choices.

Strategic Disclosure

Participants reported various decision points about their process of either disclosure or non-disclosure. In making decisions around disclosure, all 8 participants reported a heightened awareness of language when chronic mental illness or diagnosis was brought up, and particularly so in psychopathology and diagnosis classes. Participants reported listening closely to faculty, peers, and supervisors before making a decision around disclosure or referencing their diagnosis/diagnoses. Some participants (3) reported that they intentionally did not disclose to particular faculty members, due to perceived lack of understanding or discomfort from that faculty member around their diagnosis, although then choosing to disclose to a faculty member who had gone out of their way to ask students how best to support them individually.

Ada shared that a particular faculty member seemed annoyed by other requests for accommodations from students, and decided against disclosure to that faculty member. She did, however, disclose to another faculty member who was intentional about asking questions around how to support.

> There’s another professor who just emailed me for a check-in. She's like, Hey, Ada, how, like, how are you doing? I just wanna see how you're doing as an individual. And so we just had like a 30 minute meeting where we, she just asked about my life. We weren't talking about school, weren't talking about classes, grades, assignments, just talking about me. And like, she really cared, which was fabulous. I ended up disclosing at that has been really positive.

Only one participant formally disclosed their diagnoses to both their Office of Disability Services and their program, while 6 others had informally disclosed to at least one faculty member, peer, or supervisor. One participant had not disclosed any of their CMI to anyone in their program or university. While 5 of the 7 participants who disclosed their diagnoses reported no perceived stigma or what they would consider gate-keeping from the program, several did state that doing so made them feel responsible for correcting information or at risk of being tokenized. Hannah said “…I do feel very like vulnerable and like there's a spotlight on me when I do disclose that information [anorexia diagnosis] and it's, it's sometimes almost like I'm like the token representative of those diagnoses. So that can be challenging and draining.”

Other participants were strategic about which diagnoses they shared, shared first, or declined to share. The strategy making was primarily informed by safety concerns and the perceived probability of positive or supportive response from the person to whom they disclosed. For example, Cameron spoke to receptivity concerns when she shared an anecdote about interactions with a professor early in their program:

> Timeliness issues are directly related to my ADHD, and because of the medication shortages, a symptom that has been hard to manage. In my first quarter, one of my earliest professors was like, you know, even though you're just like five minutes late here and there, um, it's extremely unprofessional. And, I like immediately told her, like, I was like, I am so sorry if I've ever come off as like, disrespecting you or your time. I am grateful for the class and your availability and being there and showing up for us. Like this is something I really struggle with across the board. I made sure to like come to class on time after that for the remainder of the quarter and she still in a meeting at the end of the year, brought it up to me very passive aggressively. And that I felt like wasn't really cool because, um, she's probably one of the professors actually that I had a negative experience with that I was like, oh, I actually don't want to tell you that I have ADHD

> because why would I let you in on that part of myself if you're going to be so unhelpful about five minutes here and there.

When asked if this impacted her decisions on who to disclose to or help-seeking behaviors, Cameron said "Absolutely – I knew that professors could carry grudges without even knowing I wasn't the same as other students.' Similarly, Trinity, in explaining why she never disclosed, walked between stigma and safety:

> In my experience, and I wouldn't say even in any, you know, not disclosing to faculty or not talking about it in class openly or things like that, I don't think I would chalk that up to this stigma necessarily. I mean, maybe…I guess that is stigma. I was gonna say like a safety mechanism. Like, we're not gonna ruffle any feathers here. Like, you're good. This is not something people need to be concerned about. So we're not gonna do anything that would give people calls for concern. Um, which actually now I think is somehow stigma.

Ada reported gauging anticipated reactions often when it comes to disclosing their diagnoses, though "…I can't remember of any like specific, uh, circumstance off the top of my head, but I know like when I have chosen to not disclose, I feel like it's more of like just like a protective factor for myself or I feel like it might not be like the safest environment for me to do it." In contrast, Alice disclosed all 4 of her diagnoses during the admissions process as well as upon matriculation into her program. In her words:

> I opted to disclose all simply because my diagnoses are heavily intertwined. PTSD, anorexia, anxiety, and depression are all pretty connected. The way that I think about it's like PTSD is the umbrella diagnosis. And then the anorexia, the anxiety and the depression kind of all fall underneath it. So usually the PTSD is the driving factor for everything else varying in severity. BUT the reason I chose to disclose all of them is

> because I oftentimes don't present like I have PTSD and it might look more like depression or anxiety. So I think it's like easier for people to understand if I just share everything and then it's a little bit easier to like, oh, like she's just really anxious today. Like, that makes sense. You know, versus if I was like really anxious and they were like, I thought she had depression. Like, why is she so anxious? Um, so I just share everything for transparency’s sake. I find that to be easier than hiding.

Counseling Self-Efficacy

River’s experience in their psychopathology course prevented them from disclosing due to the language used around people with CMI, and challenged their sense of self-efficacy:

> …When you're constantly hearing about how people with certain disorders like this, rammed into our brains, especially during the psychopathology course, like the statistics of where people with these diagnoses usually end up, which is like ending their life, like completing suicide, self-harm, addiction, being unhoused. And then so naturally reading those sort of articles and then also having professors and peers around me pair it that, you know, people with these diagnoses cannot do certain things or they will end up in this certain situation. It’s definitely made me falter a bit sometimes about my ability to actually follow through with what I wanted to do. even though I know, like I've been doing it for so long, um, being almost graduating with a master's degree, like how would I be able to do that if I, if I wasn't already, you know, had the, the belief in myself that I can.

Cameron linked medication shortage induced physiological responses to her levels of perceived self-efficacy in her counseling program.

> I mean, I would say that's like, probably like one of the bigger imposter syndrome type of, or like themes in my imposter syndrome is like if I am like struggling especially… still in those moments I'm like, how am I supposed to give people advice onto how, on how to live productively and like authentically and be the highest version of yourself when I am not even like, capable of doing that right now. Like, I cannot even show up as the best, most full version of myself. I can't even meet my basic needs some of these days. So I, it definitely, there's a lot of guilt. I think that plays a lot into the guilt of like my just abilities in general. But, um, yeah, I don't know. Just feeling like very hypocritical is not a good feeling.

Help-Seeking as Reason for Disclosure

Another theme that emerged was the desire for both emotional and academic support from faculty and peers, which appears to have been consistently a driving force for the students who chose to disclose to someone in their program. This was split between students who saw topics coming up in coursework or fieldwork that they anticipated to be triggering as they related their diagnosis (n=3) and between students (n=7) who sought understanding and empathy regarding a combination of assignments, client work, or missed classes.

Hannah ended up disclosing her diagnosis of anorexia after a class on psychopathology was particularly triggering (Hannah reported that language around BMI was being taught as the primary diagnostic for anorexia, an approach that had kept her from getting appropriate care for years). Hannah said "I think it definitely affected my relationship with the professor of that class and that was really difficult for me., but I think just like her seeing like how much it [language around eating disorders] really affected me definitely changed like how we interact, which I don't think it was negative, but it is like now she knows that like how much this language affects me, I guess." Hannah did say that this professor pulled her aside at the end of the semester to ask if she had support, but that was the extent of their interactions around her disclosure.

Alice disclosed at the beginning of her program for a variety of reasons, but particularly because she "knew she had to be transparent from the beginning to get the support I would need." Alice has a number of physical disabilities, which also interact with her mental health diagnoses, and she said that knowing she would need support opened the door to a personal policy of transparency.

> Whenever issues arise, I can let them know - I'm doing my best. I will get everything to you on a timeline that I can. But I just wanted to let you know that this is where I'm at. And for the most part, all I've ever wanted for them is a little bit of grace. Um, and, you know, just humanity. Um, and that's all I could ever ask from my professors.

Positive Impact of One Faculty Member

Out of the seven students who had disclosed their diagnosis or diagnoses to someone in their program, six were able to articulate a specific experience where a single faculty member provided support that felt very encouraging and meaningful, and impacted their perceived self-efficacy. While only one student utilized formal accessibility services and disclosed their diagnoses to their full faculty, the other 6 students each had an experience where their interaction with the faculty member they had disclosed to was positive and felt that their CMI was supported. For example, Alice said support looked really balanced from a particular professor, and threaded a fine needle between over-coddling or ignoring her mental health completely.

> They have been endlessly supportive of me and the thing that I appreciate about them the most is whenever I have come back to school after being like, surgery or depressed or like missing a week or for whatever reason, um, they just kind of come up to me and they

> go, how you doing? And they don't, you know, they never pry, they're never invasive. They just, ask “What do you want to update me on? Like, what do you wanna share?” And then they ask me what I need from them and I just tell them like, this is what I need or I don't need anything. And then they just say, “Great. I'm happy to have you in class today.” And then they follow up with me as needed. And that's just been so refreshing because I historically, my experiences with professors have gone either they completely ignore you and like pretend that you didn't miss class at all and just like, kind of completely disregard the fact that you might need help or support or they get really invasive and they start crying or they assume that because you've had these things happen to you that you need like excessive support and then you're that you're not capable of handling yourself.

Cameron disclosed to a faculty supervisor, who shared their own diagnosis of ADHD with her. Camerson said of this experience:

> …having a supervisor, though, that kind of like struggles with some of the same things that I have, uh, he's just been like a very positive example of like how I can use mindfulness practices or like the things that we're telling our clients to my every day to sort of, um, help carry me along. Um, but I would say just our conversations have been helpful and positive and have given me more hope as to, um, everything I can still accomplish with this disorder. He also uses the language that I use and know around this, like hyper fixation or like executive function, and I find it the most helpful, like to use that language.

Trinity, though they did not ultimately disclose to a faculty member, immediately responded with the memory of one professor they would have had the necessity arisen:

> It didn't really ever cross my mind to like intentionally go and seek support from any of my professors. Um, if I were to though, there was one professor that I definitely would've gone to because she had that kind of energy where she was a, you know, well established counselor and full of knowledge, but like, she was still a person and that was cool. Might have helped that she would also bring her dog to class. I'm sure there was an off chance once or twice where I just talked to her about things. Um, again, maybe because she had that type of energy and demeanor, I didn't even think about it as help seeking. It was just natural. Um, so definitely, definitely one that had I been going through something, I probably would've been cool talking to her and I may have, I just blocked it out. Um, but faculty wise, besides her, I never really felt like they're intentionally showing support, um, or intentionally offering support.

Reflexive Process

As noted in Chapter 3, this researcher used a reflexive journaling process to ensure transparency throughout the study. Reflexive journaling allowed this researcher to document their reflections, thoughts, and decisions in real-time. This practice was especially critical in understanding and mitigating the potential biases and perspectives that researchers brought into the research process (Patton, 2015). By continuously engaging in reflexive journaling, this researcher was able to critically examine their positionality and maintain a dialogue with the data, which contributed to a deeper and more nuanced analysis and interpretation of the research findings (Ortlipp, 2008).

Reflexive Journals

Journal 1

I am a little concerned about repetitive nature of questions, though participant was a good sport and appeared to dig a little deeper for each. I am wary of pushing participants too much to focus on how others might perceive their diagnosis and causing harm where there was previously none or planting fears about possibly disclosing in future – also, this may be a space of countertransference. Will debrief with peer auditor.

I have some research concern around more ‘acceptable’ CMI diagnoses and what that might mean for this research – “anxiety” can often be expected in counselors in training, so even the word “disclosure” takes on a different meaning for of anxiety can be interpreted very differently by receiving party.

In following up in next interviews, I want participants to tell me language they prefer around diagnosis/mental illness etc. I know what I think about it (prefer to differentiate diagnosis from my person) but I want to give space.

Possible countertransference – I had a very similar experience in my master’s program, and I had to remind myself to stay tied to questions. Is it possible that I will use this experience to influence how I code? Bracket this. Shared this transcript with peer auditor to get some feedback on my style/q’s around countertransference showing up.

Journals 2 + 3

These interviews highlighted some gaps in my questions particularly around getting towards more experiences of stigma. I will debrief with peer auditor. I need to be more explicit about asking about what they heard said about their diagnosis or diagnoses in general throughout their time in their programs; I am trying to get a sense for what they may be absorbing around possible risks or benefits to disclosure. I'm also considering adding in some questions around structural components of their programs as it relates to the barriers and gatekeeping.

Both of these interviewees had more “acceptable” diagnoses and had been receiving support and external services for a long time. I'm curious to see if these diagnoses kind of keep stacking into a pile of similar experiences and if we'll get more respondents with other significant diagnoses and how much impact this specific diagnosis has on self stigma and self efficacy.

After talking with chair re: concerns with these more “acceptable” diagnoses; chair suggested I ask more pointed follow up question around level of severity revealed to person disclosed to, in order to ascertain more if the receiving party then understood the admission of anxiety to be a clinical disclosure.

Journal 4

This interview presented a clear differentiation between acceptable diagnosis and the more stigmatized mental health diagnoses. The student was forthcoming about having to censor themselves and live with stigma and related how damaging the stigma was to their perception of efficacy as a counselor. The student also offered perspective on advocating for themselves as a disabled student and discomfort and ableism they've experienced being put in the position to have to kind of perform their disability or demand kind of basic fairness to them and how that impacted their decision to disclose their mental health status. Adding questions pertaining to the diagnosis and psychopathology classes seems to be a helpful way of examining experiences of stigma or self-stigma in getting some rich data from that. I don't think I need to make any other adjustments at this time to my interview questions although the self-efficacy portions are still feeling a little redundant. Will consult with my advisor.

This interview set off some of the alarms I have been careful to not jump on. It was difficult to hear this student’s negative experiences, and their longing to be supported and known by their program. I do not believe this impacted how or what I asked regarding the interview, but

I took time between transcribing and coding this interview to make sure I had a little distance to read more clinically than reactively. I ask peer auditor to read these themes closely to check behind me to ensure I was not ascribing meaning that was not indicated.

Journal 5

The student was forthcoming about her diagnosis of anorexia and OCD. Interestingly, in her classes and with her professors, she seems to present with some level of self-stigma around her diagnosis of her eating disorder (preferring to disclose ‘eating disorder’ over anorexia) . I think it's going to be interesting working with students who have finished one year versus two years within their programs. Self-efficacy questions were more fruitful this time; I used more examples to illustrate.

I am beginning to see a theme around ‘whole self’ and the lack of the ability to be able to fully incorporate that into their lives as students, even as faculty here and there signal or verbalize support. I want to explore this more as I continue to code the previous transcripts.

I am beginning to recognize that students with one or more diagnoses tend to favor disclosure of some/speaking through that lens of experience more. I wonder if this relates to self-stigma, safety concerns, or the diagnosis that impacts day to day life most, or a combination thereof. Also curious as to level of awareness a participant has of this preference.

Journal 6

It was hard not to be sidetracked by thinking about what needs to be done in turns of unpacking the relationship of ADHD to the rest of the DSM and what the field understands as "mental illness"/CMI. This participant had much to offer in terms of daily impact and toll of management, as well as stigma related to symptoms of her diagnosis.

When this student was relating some negative experiences she had had with professors regarding time management and professionalism, it made me consider when I have jumped to conclusions as a faculty member working with students with apparently chronic lateness/tardy assignments and how I might be using language that throws up barriers to students who would otherwise ask for help/guidance/support. This student also kept peppering in language around not wanting accommodations because they have been annoyed by other students who get accommodations. I wonder about opening up accessibility to more students.

Journal 7

This interview was curious to me. A student with often-stigmatized diagnoses reported overwhelming support from their peers and faculty and shared some skepticism that any student would experience repercussions for disclosing. This student also did say that they have had years of therapy around disclosure and accepting themselves for who they are, and this seems to be demonstrated in how they have interacted with their program and any person they have disclosed to. I also had to set aside how I have been taught about aspects of one of these diagnoses, and that it can be difficult to accurately ascertain impact on others. My own bias was showing in my skepticism of some of the reporting here.

I had to minimize any doubts I may have had in participant's answers and investigate later whether I was projecting my own experiences onto theirs. It is very possible this student has had supportive and gentle experiences, and that their program has done an admirable job in supporting students.

Journal 8

While at first I was concerned that ADHD diagnoses would not provide as rich as an experience (perhaps my own stigma showing here – not having considered ADHD (while real and challenging!) "as serious" as other diagnoses…), these interviews are demonstrating my own lack of depth in understanding ADHD's impact and required maintenance and management. This student shared how much their ADHD diagnosis impacts every decision they make, and how inextricable it is from how they experience and manage their anxiety disorder.

My bias around ADHD has certainly been challenged again and again by participants' sharing of their experiences and reactions from their professors and programs, as well as how much internalization stigma/shame participants carry around requiring support. I wonder where I have contributed to a lack of support and where I have been able to be of meaningful guidance.

There seems to be ample fodder here for some briefs on best practices teaching briefs.

Chapter 5: Discussion

This final chapter of this study focuses on connecting the insights derived from the Interpretive Phenomenological Analysis of the lived experiences of graduate counseling students diagnosed with Chronic Mental Illness (CMI) to existing theories and research. Additionally, implications for future research, counseling practice, counselor education, and supervision will be discussed.

Overview of Methodology

This qualitative study employed IPA to explore the personal experiences of eight graduate counseling students diagnosed with CMI. In exploring the applicability of this methodology, this discussion will be guided by the findings of the study and examining how they align or diverge from previous research and the theoretical framework for this study. The foundation for this endeavor is the use of IPA, a research design that excels at exploring subjective experiences (Smith, Flowers, & Larkin, 2009).

The unique strength of IPA is its capacity to shed light on how individuals perceive and comprehend their world (Smith et al., 2009). This methodology has been used in this study to gain a deeper understanding of the experiences of graduate students in counseling programs who have a CMI. The IPA approach delves into the lived experiences of the participants and seeks to decipher the meanings they attach to those experiences (Smith et al., 2009).

The research process within this methodology involved conducting in-depth interviews with participants who have directly experienced the phenomenon under investigation (Smith et al., 2009). The use of semi-structured interviews paved the way for uniformity across participants while still allowing room for dialogic flexibility in the research (Smith et al., 2009). Once the data was gathered, the researcher embarked on a process of data analysis to uncover essential themes and patterns emerging from the data (Smith et al., 2009). Bracketing was a key part of this process, whereby the researcher's preconceptions and biases were set aside, enabling an unbiased and open-minded approach to the data (Giorgi, 2009).

Phenomenological qualitative research demands that the data be approached without any preconceived categories or frameworks (Smith et al., 2009). The ultimate goal is to identify essential themes and patterns that surface from the data and to eloquently capture the essence of the studied phenomenon (Smith et al., 2009). To ascertain the rigor and trustworthiness of the research, strategies of peer debriefing and maintaining a reflective journal to record biases and assumptions were employed (Creswell & Poth, 2018).

Research Question

The primary purpose of this study was to understand the lived experiences of graduate counseling students diagnosed with chronic mental illness (CMI). By employing an Interpretive Phenomenological Analysis (IPA), this research aimed to explore how these students navigate their academic and professional training, manage their mental health, and perceive the stigma associated with their conditions.

Summary of Findings

The diversity of the participants, their diagnoses, and their experiences added depth to the study, revealing common themes such as CMI as a strength, the importance of outside support systems, the desire to be known as whole beings, and the daily impact of managing their symptoms. It was found that graduate students with CMI believe that their CMI enhances their empathy and skills in working with clients, indicating a close relationship between personal experiences of CMI and perception of professional abilities. At the same time, participants reported times where their self-efficacy was diminished by negative comments from others related to CMI, suggesting a complex relationship where counseling self-efficacy can be enhanced but also can be harmed.

Recognizing and acknowledging the significance of outside support systems were intrinsic to the management of their diagnoses. Strategic disclosure emerged as a crucial component in balancing the desire to be known with fears of stigma, often informed or accompanied by self-stigma. Participants reporting being mindful of those in their environment (both faculty and peers) and using the information gained from watching those around them to determine if it was safe to self-disclose. These findings highlight the complexities surrounding disclosure decisions—balancing safety concerns, anticipated reactions, and the need for emotional and academic support. Such factors pivotally shaped the experiences of the students navigating their academic and professional journeys.

Finally, the daily challenges of managing CMI as a counseling graduate student were navigated with coping systems like physical activity and routine-based practices. The supportive involvement from individual faculty members played a pivotal role in shaping the positive experiences of the participants, indicating a strong need for increased empathy and understanding within academic institutions.

Discussion of Results

The analysis of the data presented in Chapter 4 provides us with deeper insights into the lived experiences of graduate counseling students diagnosed with chronic mental health illness (CMI). This chapter discusses these results in-depth and positions them within broader academic discourse.

CMI as a Strength

Participants viewed their experiences with CMI as a strength, particularly in their roles as counselors. This aligns with existing research which, for example, asserts that personal experience with mental health issues can enrich empathy and deepen understanding of client experiences (King et al., 2018). Specifically, participants in this study reported that their firsthand understanding of mental health struggles allowed them to connect more profoundly with clients facing similar issues, promoting a sense of shared experience and trust. Furthermore, their experiences promoted resilience and versatility, enabling them to handle stress and adversity both personally and professionally.

Outside Support Systems

The integral role of external support systems corroborates existing literature on the importance of these networks for individuals with CMI (Smith et al., 2017). These systems were instrumental in navigating the participants' academic journey, signifying the need for programmatic inclusion of such support systems. Family, friends, and mental health professionals formed the cornerstone of these networks, providing emotional support, practical advice, and encouragement.

Desire to Be Known

Disclosure in a supportive environment can be a powerful tool for students dealing with CMI, improving their emotional well-being along with the overall academic experience, as found in research by Vidourek et al. (2014). This research reinforces the critical importance of creating understanding and acceptance within academia for those dealing with CMI. Participants voiced a yearning to disclose their CMI to their academic peers and faculty, aligning with notions of 'authenticity' in education (Ryan & Deci, 2001). This underscores the importance of creating safe spaces within academia to enable such disclosure. Many students described this desire as an effort to reduce the isolation often felt from having a CMI and to foster a more inclusive environment. They expressed that sharing their experiences openly would not only benefit their own well-being but also might contribute to a more understanding and supportive community for other students with similar challenges. Perhaps, also, it is important inasmuch as such disclosures put a human face on these diagnoses and, by extension, potentially encourage a more compassionate stance from other students toward people with CMI.

Daily Impact

In their management of their CMI, study participants revealed implementing daily coping strategies, underscoring their significance during rigorous graduate school stress. This mirrors existing research findings that emphasize the crucial role of physical activity along with other coping strategies for individuals living with CMI (Hoffman et al., 2020). Essential elements in symptom management were noted by participants to include routine activities such as exercise (Callaghan, 2004), practices of mindfulness (Grossman et al., 2004), and keeping a structured daily schedule (Spencer, 2018). Furthermore, participants were observed to regularly use professional mental health facilities and engage in self-care techniques like ensuring adequate sleep (Harvey, 2011), adhering to a healthy diet (Jacka et al., 2013), and preserving social ties (Umberson and Montez, 2010) to enhance their overall well-being.

Role of Stigma

The experience of self-stigma and fear of judgment depicted in this study also have been echoed in previous research, exponentiating the deleterious effects of stigma on mental health (Corrigan, 2004). Participants reported being cautious about revealing their diagnoses due to anticipated negative reactions and the potential impact on their professional reputations. This is in accordance with the findings of Livingston and Boyd (2010), who identified that fear of judgment often deters individuals from divulging their mental health condition, potentially impacting their professional standing negatively.

Participants in this study expressed concerns over the disclosure of their diagnoses, fearing negative reactions and potential damage to their professional standings. This ingrained stigma often drives individuals towards self-induced seclusion and hesitance in seeking necessary help or adjustments (Rüsch et al., 2009; Stuart, 2016). Given these findings, it might be prudent for counseling programs or faculty to develop some sort of initiatives or program designed to reduce stigma within academic environments to counter potential adverse outcomes (Clement et al., 2015; Hatzenbuehler, Phelan, & Link, 2013).

Motivator for Career

The presence of stigma as a driver for career choice is a novel finding in this study, indicating the intersectionality of personal experiences and professional aspirations. This is a possible demonstration of how personal experiences and professional goals can intersect (Liu et al., 2020). The majority of participants noted that their negative experiences with stigma fueled their passion for the counseling field, desiring to advocate for others with CMI and to work towards systemic change. They felt that through their careers, they could challenge misconceptions, promote empathy, and support those navigating similar challenges, thus transforming their personal adversity into a catalyst for professional growth and societal impact.

Help-Seeking as Reason for Disclosure

Participants strategically disclosed their diagnoses to access emotional and academic support, a practice supported by existing literature, emphasizing the importance of trusted relationships in support seeking behaviors (Dejman et al., 2015). By revealing their mental health status to select individuals, participants were able to receive tailored support that was crucial for their academic and personal success. Trustworthy relationships with faculty, advisors, and peers created a safety net, ensuring that students could access necessary accommodations and understanding when needed.

Positive Impact of One Faculty Member

The impactful role of supportive faculty aligns with research underscoring the essential role of faculty in fostering student success (Kim & Sax, 2009). Often, participants singled out one particular faculty member whose empathy, understanding, and proactive assistance made a significant difference in their academic journey. This faculty member's support included offering flexible deadlines, providing a listening ear, and advocating for the students within the academic institution. This positive relationship not only improved the students' academic performance but also enhanced their overall sense of belonging and confidence within the educational environment.

Theoretical Connections

This study's findings contribute valuable insights to an understanding of Bandura's Social Cognitive Theory. Among graduate counseling students with chronic mental illness (CMI), this study found that their journey in academic and professional settings to be deeply entwined with their self-efficacy beliefs. These beliefs, as Bandura proposed, are integral in shaping individuals' perception about their abilities to achieve desired outcomes. Bandura's theory stresses the role of individuals' self-perceptions regarding their ability to succeed and achieve desired outcomes (Bandura, 1978). The emphasis on personal and environmental factors that shape individuals' beliefs about their capabilities fits well within the narrative accounts provided by participants of this study.

1. **Interplay of Personal and Environmental Factors:** Consistent with Bandura's theory, participants' narratives revealed that their struggle with self-efficacy did not occur in

isolation. They were continuously influenced by a complex interplay of personal experiences related to their mental health diagnoses and professional identity, along with the environmental factors that surrounded them.

2. **The Act of Strategic Disclosure:** The participants' strategic choices concerning when and to whom they disclose their CMI diagnoses demonstrate Bandura's concept of reciprocal determinism, where individuals actively shape and are shaped by their environment. These decisions were driven by their perceptions about the potential reactions of faculty, peers, and supervisors, emphasizing the importance of contextual factors in the process of self-efficacy development.
3. **Role of Help-Seeking Behavior and Support:** Our study also reflects Bandura's emphasis on the value of support networks in self-efficacy development, evidenced by participants seeking emotional and academic support following disclosure. Positive interactions with empathetic faculty members were found to substantively enhance participants' self-efficacy, underscoring the role of social influences in shaping self-beliefs.
4. **Motivation-Fueled Career Choices:** For some participants, the stigma surrounding mental illness turned into motivation to help others in similar situations and a belief that they could effectively do so. This aligns with Bandura's concept of self-efficacy, where the belief in one's ability to succeed can lead to the pursuit of challenging tasks or career paths.
5. **Daily Management and Coping Strategies:** Participants’ use of coping strategies to manage their CMI symptoms underpins Bandura's assertion that self-regulation is a crucial component of self-efficacy. These strategies allowed participants to improve their

mental state, potentially enhancing their self-efficacy beliefs over time. Consistent with Bandura’s work, then, strategies for self-regulation seem critical for counseling graduate students with a CMI.

6. **Impact of Positive Faculty Support:** Positive interactions with understanding faculty members were key in shaping students' self-efficacy and overall experience, reinforcing Bandura's idea about the significant role of supportive relationships in self-efficacy development.

At the same time, however, this study also revealed some findings that diverged from aspects of SCT. Despite Bandura's emphasis on self-efficacy, participants often harbored high levels of self-stigma and internalized negative beliefs about their diagnoses. This finding suggests that self-efficacy might not be the sole determinant in decision-making or help-seeking behaviors, indicating the profound impact of internalized stigma. Further, the environment played a critical role in shaping self-efficacy beliefs. Contradicting SCT, some participants withheld their diagnoses from faculty members due to anticipated discomfort or misunderstanding, showing that external factors significantly influence self-efficacy beliefs. It seems necessary, then, to consider the importance of social context in the counseling self-efficacy of students with a CMI.

In summary, this study reveals an intricate connection between personal experiences, environmental characteristics, and social interactions, echoing Bandura's Social Cognitive Theory. However, it also challenges traditional SCT confines, emphasizing the complex factors shaping the experiences of students with CMI. The concept of self-efficacy provides critical insights into the academic and professional struggles faced by these individuals. By acknowledging these students' multifaceted experiences, educators and supervisors can implement targeted interventions and supports that enhance self-efficacy, contributing to their success in their counseling programs.

Discussion

Positioning of Current Findings within the Existing Research

The aim of this qualitative study on the experiences of graduate counseling students with chronic mental illness is firmly situated within a wider body of research on mental health, counselor education, and qualitative methodologies. This positioning is vital in understanding the relevance and implications of this research in the existing scholarly discourse.

The literature review in Chapter 2 emphasized the prevalence and significant impact of mental health issues among students (Evans et al., 2018; Klein et al., 2023; Levecque et al., 2017; Liu et al., 2014), particularly in objectively intense programs such as counseling (Klein et al., 2023). Notably, there is a striking gap in the research related to the experiences and struggles of graduate counseling students with chronic mental illness. This study sought to begin to fill this void, offering a more refined understanding of the complexities and nuances of these students' experiences (Acri et al., 2019).

This research, framed by Bandura's Self-Efficacy Theory, is particularly centered around the lived experiences of these students, drawing on the gaps in the literature concerning the long-term implications and unique stressors specific to counseling graduate students with chronic mental illness. It adds to the ongoing dialogue on chronic mental illness among graduate counseling students, seeking to unearth the lived experiences, challenges, coping strategies, and resilience of these students.

In addition, this study highlights the gatekeeping challenges faced by counseling faculty (Homrich, 2009), the importance of understanding and distinguishing impairment from disability, and the effects of self-stigma on students (Corrigan and Rao, 2012; Livingston & Boyd, 2010). It also underscores the significance of the wounded healer concept in counseling, suggesting therapists with personal mental health struggles may be more empathetic and understanding towards their clients (Banaji and Greenwald, 2013).

Key themes emerged from this study such as viewing chronic mental illness as a strength, the importance of outside support systems, the desire to disclose diagnoses, and the daily impacts of these diagnoses (Acri et al., 2019). These themes resonate with findings of previous researchers (Klein et al., 2023; Levecque et al., 2017; Liu et al., 2014;), adding depth and specific insights to the existing discourse.

This research deepens the understanding of the complex experiences of graduate counseling students living with chronic mental illnesses. It contributes to bridging the scholarly gap (Mowbray et al., 2006; Salzer, 2012), providing a more nuanced understanding of the challenges and coping mechanisms of these students. Notable findings include the perception of their illness as a strength, the significance of external support systems, a desire to disclose their diagnoses, the daily impacts of these illnesses, the interplay of personal and environmental factors, and the practice of strategic disclosure. In addition, the critical role of help-seeking behavior, importance of support, motivational influence on their career choices, the positive impact of faculty members, and consequences for counselor education and supervision were also highlighted. The findings add to the ongoing discourse on chronic mental illness in the context of counseling education, aiming ultimately to better support these students in their academic and professional pursuits, and faculty and supervisors in supporting the students in front of them (Smith, 2019; Ratts, 2013; Lumadue and Duffey, 1999).

Intersectionality of Participants

The study participants' experiences were not only shaped by their mental illness but also by other intersecting identities such as race, gender, sexual orientation, socioeconomic status, and more. These intersectional factors added layers of complexity to their experiences of stigma, fear of judgment, and decisions around disclosure.

LGBTQ+ and BIPOC Identities

One participant, who identified as a person of color and LGBTQ+, shared, “The stigma I face isn’t just about my mental illness. It’s compounded by my race and sexual orientation, which makes me even more cautious about who I disclose my diagnoses to. I can’t hide my skin color, but other factors – I have to choose when to come out or when to stay in the closet, so to speak.” Such a poignant statement highlights the complexities of those who likely experience multiple identity-based stigmas and judgments.

Disability

The dual presence of a physical or learning disability alongside a chronic mental illness (CMI) introduced additional layers of complexity and challenge to stigma and disclosure experiences among participants. Many students described encountering compounded stigmas—in one instance for their mental health condition and in another for their physical or learning disability. Often, this intersectional stigma led to a heightened sense of vulnerability and isolation, impacting their willingness to disclose either condition within academic and social environments.

Students with both CMI and other disabilities frequently had to navigate intricate decisions around disclosure. They weighed the potential benefits of receiving accommodations and support against the risks of encountering prejudice or differential treatment. For some, the fear of being doubly stigmatized led to a strategy of selective disclosure, where they would reveal one condition but conceal the other. One (Alice) found that disclosing both sets of conditions could sometimes alleviate the burden, as it opened the door to more comprehensive support systems tailored to their diverse needs.

Moreover, the intersection of disability and CMI influenced the practicality of disclosure. Participants highlighted the necessity for understanding and flexibility from faculty and peers. Commonly, the compounded nature of their conditions required more nuanced and individualized accommodations which, when granted, might significantly enhance their educational experiences (Cameron and Ada both reported learning disabilities that they were uncomfortable disclosing in order to recieve accommodations). Nonetheless, the presence of dual conditions underscored the critical importance of fostering deeply inclusive environments where nuanced and intersectional needs of students could be recognized and adequately supported.

Implications for Counselor Education and Supervision

A number of implications emerge from this date for counselor education programs, faculty, and supervisors. These include the importance of a supportive environment, individualized support tailored to the unique needs of students, culturally competent training, and awareness of language around diagnoses.

Supportive Environment:

The academic and professional development of counseling graduate students with CMI may greatly benefit from the creation of an inclusive and supportive learning atmosphere. Counseling programs can develop targeted awareness programs to educate faculty and peers about the unique challenges faced by these students. Additionally, training staff to provide appropriate support and implementing policies that foster empathy and understanding within the counseling community can help alleviate stress and promote well-being. Establishing safe spaces where counseling students can openly discuss their experiences and struggles without fear of judgment or discrimination will contribute significantly to their success and ongoing resilience. Implementing practices that encourage open dialogue can cultivate a sense of belonging, thereby reducing the stigma (Corrigan & Rao, 2012)

In a qualitative study conducted in the United Kingdom, Quinn et al. (2009) interviewed students with mental health diagnoses to understand their perspectives and experiences related to university student health services. Participants identified the importance of increased mental health awareness initiatives to provide students with the opportunity to share their experiences more easily with the university community. In addition, some respondents expressed a belief that creating a “culture of openness” would acknowledge and affirm the experiences of students with mental health diagnoses and provide support.

Individualized Support

Recognizing the unique needs of students with CMI will assist faculty and supervisors in improving the academic and personal achievements of these students. For example, collaborating with the university-wide office that supports students with disability(ies), often called the Office of Disability Services (ODS), can be pivotal in enhancing the effectiveness of individualized support for counseling graduate students with CMI, The ODS can provide a structured framework for facilitating accommodations and ensuring that the necessary resources are available to address the students' unique needs. By working closely with the ODS, institutions can develop comprehensive support plans that include academic accommodations, assistive technologies, and access to specialized counseling services. Additionally, this partnership can help streamline the process for students to receive accommodations, thereby reducing the administrative burden on them and allowing them to focus more on their academic and professional development. Regular communication between the students, faculty, and the ODS is essential to adapt support plans as needed and to ensure that all parties are aligned in their efforts to foster a supportive and inclusive educational environment.

As emphasized by most participants in this study (only 1 had formally disclosed all diagnoses to receive formal accommodations), however, it appears that most graduate counseling students prefer not to opt into formal services, citing negative experiences as undergraduates or current fear of judgment. 5 participants instead spoke directly to a professor regarding academic support without contacting the ODS. In these situations, many professors struggle with deciding if they should provide the academic accommodation based on the student's self-report or seek assistance from the ODS. Documentation of an approved accommodation plan from the OSD provides professors with reassurance that such requests have legitimacy. Most often, professors have the discretion to grant temporary academic accommodations based on their own best judgment. Faculty need specific support and education about managing accommodations for students with CMI, especially when they fall outside the institution's formal accommodations process.

Culturally Competent Education

Counselor educators should be culturally competent and sensitive to the intersectionality of identities (Sue & Sue, 2012). Awareness of the cultural impact on mental health issues can enhance the quality of educational services. Counseling graduate students with CMI benefit immensely from an education that is not only supportive of their mental health needs but also culturally competent towards nuances of identity. To achieve this, institutions might implement specific strategies that address the nuances of cultural competence in the context of graduate counseling education.

While CACREP accreditation incorporates cultural competence into its requirements, institutions might offer specialized training programs focused on cultural competence and its impact on mental health. These training sessions could be designed to help students understand the cultural dimensions of mental illness, including how cultural beliefs and values influence perceptions of mental health and treatment approaches (Sue & Sue, 2016). Additionally, training could cover the importance of culturally sensitive communication, helping students understand the impact of their words. In fact, simply reminding students at new student orientation and throughout their program that they must be mindful that they do not know what challenges their peers are facing. Similarly, highlighting personal attributes of developing counselors, such as the triad of dispositions that comprise a multicultural orientation (cultural humility, cultural comfort, and cultural opportunities; Hook et al., 2017) can support the education and development of all students.

Awareness of Language Around Diagnoses

The language used when discussing mental health diagnoses holds significant power in shaping perceptions and experiences. Educators and peers should strive to use respectful and person-first language, whether referring to real clients and peers or in hypothetical scenarios during training, even while acknowledging that some clients may not prefer person-first language. That is, language that uses diagnoses as adjectives or descriptors (e.g., a borderline client) should be avoided in the classroom and in supervision. Instead, saying "a client diagnosed with Borderline Personality Disorder" rather than "a borderline client" emphasizes individuality, helps mitigate stigma, and acknowledges that errors in diagnosis are not infrequent, particularly for those from minoritized groups (Teplin et al., 2023) Students with CMI are particularly attuned to the language used around diagnoses, both their own and those of clients, and this sensitivity significantly influences their decisions to disclose or not disclose their diagnoses or ask for help.

Recommendations for Future Research

This study illuminates the rich and complex experiences of graduate counseling students managing CMI. Therefore, it is recommended that future research delve deeper into understanding the various aspects of these experiences, such as the impact of different types of support systems and coping strategies on their academic and professional success, and the role of institutional policies and practices in shaping these experiences.

One finding in the current study that seems to warrant additional attention is the importance of critical events. People and systems became safe or unsafe to students with CMI based on critical events such as a judgmental description of a person with CMI (negative) or an individual emphasizing being a safe space for all students (positive). Additional empirical attention seems warranted focused more uniquely on these critical events than was the case in the current study.

Additionally, researchers should aim to delve deeper into the role of intersectionality within academic environments, particularly within the context of CMI. The objective is to uncover a richer understanding of how convergent identities—race, gender, socioeconomic status, and sexual orientation, for instance—influence students' experiences. By illuminating these gaps, researchers could help define the nuanced barriers and facilitators that affect students' access to mental health resources, the efficacy of their coping strategies, and their overall academic journey (Garcia & Pettis, 2021). Additionally, research that acknowledges and addresses the specific stressors faced by students from marginalized ethnic backgrounds—such as cultural stigma around mental health and discrimination—could yield a more holistic view of these students' experiences (Sue et al., 2007).

Another critical avenue for future research is the unique set of challenges faced by People of Color (POC) and individuals from other marginalized communities. Often, these students encounter systemic obstacles in graduate programs—such as systemic racism, cultural insensitivity, and a lack of representation—that may augment the hardships related to CMI (Yosso, 2005). Research by the National Center for Education Statistics (NCES) supports this assertion, noting that students from marginalized backgrounds face increased challenges due to systemic barriers present in higher education environments (NCES, 2021). Recognizing and understanding the added barriers these individuals face—like implicit biases and microaggressions from peers, faculty, or supervisors —can lead to the development of targeted interventions that cultivate a more inclusive and supportive academic environment. As such, in the future researchers should focus on tailored support systems that take into account the unique experiences and needs of POC and marginalized individuals in graduate education (Matias, 2013). The goal should be to create interventions that not only alleviate CMI but also foster an inclusive and equitable academic environment (Collins, 2015).

Additionally, future scholars could employ mixed-methods research to combine the depth of qualitative data with the generalizability of quantitative data. Qualitative methods, such as interviews and focus groups, can provide rich and detailed narratives that highlight personal experiences and insights. These narratives, when complemented by quantitative data such as surveys or standardized assessments, can produce a more holistic understanding of the issues faced by graduate counseling students with CMI. Additionally, quantitative methods can validate qualitative findings and facilitate the identification of patterns and trends across larger samples.

This dual approach ensures that research findings are both deeply insightful and broadly applicable.

The current study utilized data collection at one point in time. Research is still needed that follows students with CMI over time. Time-series case studies and longitudinal designs are essential for understanding the long-term impacts of CMI on students' academic and professional trajectories. By following students over several years, researchers can observe how their mental health, coping strategies, and academic performance evolve. This approach can highlight which support mechanisms are most effective in the long run and identify critical periods where students and early professionals might need additional support. Additionally, longitudinal data can provide evidence on the sustainability of interventions and policies, ensuring that resources are directed toward practices that offer lasting benefits.

Another finding that seems to warrant additional exploration is the criticality of individualized coping strategies. Exploring the effectiveness of different coping strategies across various academic disciplines can provide valuable insights into managing CMI. This research could identify which strategies—such as mindfulness, cognitive-behavioral techniques, or peer support groups—are most beneficial for students in specific contexts. Understanding the situational effectiveness of these strategies allows institutions to offer more personalized and effective support services. Additionally, identifying factors that influence the success of these strategies, such as the availability of resources or faculty support, can further refine intervention programs.

Future researchers also could examine how institutions play a pivotal role in shaping the experiences of students with CMI through policies and practices. Future research should analyze how different universities handle issues like disclosure, accommodations, and mental health services. Comparative reviews can identify best practices and highlight areas where policies might fall short. By understanding the institutional factors that contribute to a supportive or detrimental environment, researchers can advocate for policy changes that promote inclusivity and mental well-being.

While such institutional policies and practices are important, understanding the perspectives of faculty and peers toward students diagnosed with a CMI can enrich the understanding of how students with CMI navigate their academic environments. Faculty observations can provide insights into academic performance, classroom behavior, and engagement, and understanding impairment versus disability, while peer observations can offer a view into social interactions and informal support networks. This triangulated data approach helps mitigate the biases associated with self-reported data and provides a more well-rounded perspective on the student experience. Understanding how faculty and peers perceive and support students with CMI can inform the development of training programs and initiatives aimed at fostering a more inclusive and empathetic academic community. Understanding faculty perspectives is crucial in comprehensively addressing the experience of students with CMI. Faculty attitudes and beliefs about mental health can significantly influence their interactions with students and their willingness to provide necessary support and accommodations and, by extension, impact the student experience. Researchers can investigate potential biases and stigma held by faculty members, as these can create barriers to effective support for students with CMI. Studies might examine how faculty perceptions are shaped by their own experiences, training, and institutional culture. Additionally, assessing the impact of faculty biases on student outcomes can help institutions develop targeted training programs aimed at reducing stigma and promoting empathy. By incorporating faculty perspectives, future research can offer valuable insights into creating a more supportive academic environment that is better equipped to meet the needs of students with CMI.

Further, there is a need for research on interventions to reduce both external and self-stigma related to CMI among counseling students. Such research could guide the development and evaluation of inclusive strategies for counseling programs (Thornicroft et al., 2016). While the need for stigma reduction is apparent, future researchers could explore a variety of speculative approaches to mitigate both external and self-imposed stigma related to CMI among counseling students. This research might investigate the potential effectiveness of different anti-stigma interventions such as targeted psychoeducation programs, peer support groups, and advocacy campaigns within diverse educational settings. Additionally, researchers might consider examining the impacts of integrating stigma reduction efforts into the core curriculum of counseling programs.

Limitations of the Study

There are a number of limitations in the current study that must be considered in contextualizing the findings.

Expand the Sample Size and Diversity

First, a limited sample size and lack of diversity among participants are notable limitations. Although themes emerged across participants, it is unknown the extent to which these transfer to other students. The findings are based on the experiences of 8 participants, which may not be representative of the broader population of graduate counseling students with CMI. It is unknown, for example, the extent to which non-participants might differ from participants. It is not hard to imagine, however, that current students with the most negative experiences might be hesitant to speak to these experiences for fear of being identified and some type of retaliation.

It is vital to this research topic that future researchers expand the sample size and diversity in future research to continue to better understand the experiences of graduate counseling students with Chronic Mental Illness (CMI). This ensures a comprehensive perspective is gleaned that considers the array of unique challenges and support requirements stemming from a myriad of cultural, ethnic, and socioeconomic backgrounds. Additionally, the role of geographical location and its associated variations in resources, stigma, and learning methodologies on CMI management in academic settings could be further explored. A consideration of the unique experiences of doctoral students in counselor education also could shed light on the heightened stress related to doctoral-level studies, including dissertations and career uncertainties.

Limited Generalizability

Similarly, the scope of this research was focused on the experiences of graduate counseling students, which limits the generalizability of the findings to other student populations or professional fields. Future researchers should consider expanding the scope to include a wider range of participants to better understand the lived experiences of students living with CMI.

Bias

Additionally, potential researcher bias is inherently a limitation of qualitative research. While there were numerous safeguards in place to increase the trustworthiness of the data collection and analysis processes, it cannot be categorically ruled out that researcher bias may have influenced the interview process, interviewee responses, and/or interpretation of the raw data. Subsequent research on the topic will continue to better flesh out these lived experiences with more confidence and certainty.

Conclusion

This research provides a first step in the examination of the lived experiences of graduate counseling students with Chronic Mental Illness. It reveals the profound strength and resilience these individuals develop through their experiences, while also underlining the critical importance of robust support systems and the relief and support that strategic disclosure of their diagnoses can bring. It brings to light the multifaceted identities and additional complexities faced by these students, which demand nuanced and personalized support mechanisms. Emphasizing the need for inclusive environments, cultural competence, and considerate language around diagnoses, this study is a call to action for further research and practical implementation of changes. It highlights the fundamental role of support, understanding, and cultural sensitivity in shaping the academic and professional journeys of these students, thus offering a valuable perspective to the ongoing dialogue on the lived reality of chronic mental illness in the field of counselor education.

Appendix A: CACREP Faculty Liaison Participant Recruitment Message

Dear Faculty Liaisons,

I am writing to request your assistance in sharing information about my dissertation study with your counseling graduate students. My study is titled "Experiences of Counseling Graduate Students with Chronic Mental Illness," and its purpose is to explore the experiences counseling graduate students with mental illness

I am seeking participants who are either currently enrolled in a counseling graduate program or participated in a program through one semester of fieldwork in the last 3 years (and either graduated or did not complete) and have a diagnosis of a chronic mental illness. The study will involve an online qualitative interview, which will be conducted using a video conferencing platform. The interview will take approximately 60-90 minutes and will be audio and video recorded. The recording will be kept confidential and will be used for transcription purposes only.

I am hoping to recruit participants from a range of CACREP accredited counseling graduate programs to ensure a diverse sample. As a faculty liaison, you have a unique opportunity to share information about my study with your students and encourage them to participate. Your support in this matter would be greatly appreciated.

If you are willing to share information about my study with your students, I have attached an informational flyer that provides details about the study, eligibility criteria, and contact information. You may also feel free to forward this email to your students or post the flyer in your program's online portal or other communication channels.

Thank you for your consideration and support. Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,

MK Curry, mcurry@wm.edu

Appendix B Flyer:

Experiences of Counseling Graduate Students with Chronic Mental Illness

Are you currently in a counseling graduate program, or have you been in a cdounseing program within the last 3 years, and have a a diagnosis of a chronic mental illness? If so, you are invited to participate in a research study exploring your experiences as a counseling graduate students with mental illness and ways to better support them in their academic and professional pursuits.

Participation in the study will involve an online qualitative interview, which will take approximately 60-90 minutes and will be conducted using a video conferencing platform. The interview will be audio and video recorded and will be kept confidential.

Eligibility Criteria:

- Currently enrolled in a counseling graduate program or enrolled in a counseling gradute in the last three years (does not have to have graduated)
- Diagnosis of a chronic mental illness
- Completed one semester of fieldwork

To participate or for more information, please contact the researcher at mcurry@wm.edu

Appendix C Participant Suitability Questionnaire

1. Status of enrollment at time of interview (currently enrolled; graduate; did not finish)
2. What is your diagnosis/es of CMI?
3. What is/was your counseling specific track?

Add in demographics here??

4. What is your ethnic, cultural, and or racial identity?
5. What is your gender identity?
6. What is your sexual orientation?

Appendix D Informed Consent

To be shared via Docu-Sign

Title of Study: *Experiences of Counseling Graduate Students with Chronic Mental Illness*

Researcher: MK Curry, mcurry@wm.edu

Purpose: The purpose of this study is to explore the experiences of counseling graduate students with mental illness in order to understand the challenges they face and to identify ways to better support them in their academic and professional pursuits.

Procedures: As a participant in this study, you will be asked to participate in an online qualitative interview. The interview will be conducted using a video conferencing platform (e.g., Zoom, Skype). The interview will take approximately 60-90 minutes and will be audio and video recorded. The recording will be used for transcription purposes only and will be kept confidential. The recording will be destroyed at the end of the study.

Risks: There is minimal risk associated with participating in this study. However, discussing personal experiences related to mental health may be uncomfortable or triggering for some participants. If you experience any discomfort or distress during the interview, you may choose to discontinue participation at any time. You will be provided will a list of online mental health supports and counseling services.

Benefits: By participating in this study, you will have the opportunity to share your experiences and contribute to a better understanding of the challenges faced by counseling graduate students with mental illness. Your participation may also help inform counseling programs and mental health professionals about how to better support graduate students with mental illness.

Confidentiality: Your identity will be kept confidential in all aspects of the study. Your name and identifying information will be kept separate from the data and any reports or publications resulting from the study. Your data will be stored on a password-protected computer and will only be accessible to the researcher and authorized research staff.

Voluntary Participation: Your participation in this study is completely voluntary. You may choose not to participate or to withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision to participate or not to participate will not affect your current or future relationship with the researcher or your academic program.

Contact Information: If you have any questions or concerns about the study, please contact the researcher MK Curry.

If you have any questions or concerns about your rights as a participant in this study, you may contact the Institutional Review Board at William and Mary.

By signing below, you acknowledge that you have read and understood the information provided in this informed consent form and that you freely consent to participate in this study.

Appendix E: Mental Health Support and Resources

1. National Suicide Prevention Lifeline: A 24/7, free and confidential support for people in distress. Also provides prevention and crisis resources. Call 1-800-273-TALK (1-800-273-8255) or use the online chat.
2. Crisis Text Line: 24/7 support via text message. Text HOME to 741741 from anywhere in the United States, anytime, about any type of crisis.
3. 7 Cups: Provides online therapy and free support to people experiencing emotional distress by connecting them with trained listeners. You can chat with a listener for free 24/7. Visit their website for more details.
4. NAMI Helpline, National Alliance on Mental Illness: Monday through Friday, 10 am–6 pm, ET. Provides information, referrals and support to people living with a mental health condition: 1-800-950-NAMI (6264) or info@nami.org
5. Veterans Crisis Line: Connects veterans in crisis (and their families and friends) with qualified, caring Department of Veterans Affairs responders. Call 1-800-273-8255 and Press 1, chat online at VeteransCrisisLine.net/Chat, or text to 838255.
6. SAMHSA’s National Helpline: 1-800-662-HELP (4357), offers referral and information services (in English and Spanish) for individuals and families facing mental health and/or substance use disorders.

Please note: These resources offer immediate support but are not a replacement for professional advice, diagnosis, or treatment. Always reach out to your healthcare provider for any questions you may have regarding a medical condition. In case of an emergency, call your local emergency number immediately or visit the nearest emergency department.

Appendix F Interview Questions

1. As we get started, could you just tell me a bit about yourself, anything you want me to know?
2. What motivated you to pursue a degree in counseling?
3. As I think you know, I am interested in understanding people’s experiences of being a counseling graduate student with a mental illness. Can you describe your experiences as a student with a mental illness?
    a. Possible follow-up – If they only describe positive OR negative experiences, follow-up about the other.
4. What was your experience of disclosure or non-disclosure of your diagnosis to peers/faculty/supervisors?
    a. If you have not disclosed/did not disclose your diagnosis, can you describe the experience of keeping it private?
    b. Do you feel like disclosing or not disclosing your chronic mental illness affected your relationships with your peers or professors in the counseling program? If so, how?
5. Did you have any experiences where you felt stigmatized or discriminated against by your peers, instructors, or counseling clients due to your diagnosis? If so,
    a. Did stigma affect your ability to seek help or disclose diagnosis to others?
    b. Follow-up questions if/as needed to assess stigma from others and self-stigma.
6. Did you experience or perceive any challenges or strengths in fieldwork as it may relate to your diagnosis?

7. Have you ever felt that there were barriers or "gatekeeping" practices in your program that were related to your diagnosis?
    a. Can you describe how these barriers have affected your academic journey and how you've managed to navigate them?
8. What coping strategies helped you with the challenges of being a counseling graduate student with a mental health diagnosis?
9. What did support look like from the counseling program, your peers, or professors?
    a. Have there been instances where positive feedback or encouragement from others has helped you overcome challenges associated to your diagnosis in your counseling profession?
10. Has/did your mental illness impact you experiences around your abilities as a counselor?
    a. Possible follow-up (goal is to get information about how both beliefs and emotions/physiology influenced self-efficacy)If participants speaks only to beliefs - How do physiological and emotional states impact your belief in your ability to succeed as a counseling graduate student managing a chronic diagnosis? If participant speaks more to emotional dysregulation – How did that influence your beliefs about your ability as a counselor?
    b. Can you describe a success you've had in your counseling training that enhanced your belief in your abilities?
11. Can you share an instance where your self-efficacy was tested during your graduate studies?
12. Was/how was this related to your mental illness ? How did you navigate this situation?

13. Could you tell me about any professors, supervisors, or mentors who have influenced your self-efficacy beliefs in your counseling career?
14. Possible follow-up – If they only speak to positive OR negative influence on self-efficacy, ask about the other.
15. Is there anything about your experience that seems important for me to know that I have not specifically asked about?

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