ELVIS AND THE NORTHERN LIGHTS

A Psychology Professor's Struggles with
Mental Illness and Addiction

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An Ironically Dehumanizing Profession

The great thing about irony is that it splits things apart, gets up above them so we can see the flaws and hypocrisies...

—David Foster Wallace

The primary purpose of clinical psychology—my doctoral field of study—is to help people live more satisfying and functional lives. Most clinical psychologists either treat mental illness, or conduct research to make treatments more effective. Practicing clinicians then use these treatments, along with insights gained through their career experience, to promote positive change in patients' and clients' thinking and behavior. Although the relative emphasis placed on career experience versus research varies across therapists and disciplines, psychologists, psychiatrists, social workers, and other mental health professionals share the same goal—to reduce human suffering in ways consistent with the ideals, moral standards, and cultural values of their clients.

Until recently, I hadn't practiced therapy since completing my internship at the University of California San Diego in 2000. For twenty-four years, I conducted research to prevent delinquency, substance use, and suicide among impulsive boys and girls raised in traumatic environments and other high-risk situations. Neighborhood violence, school disadvantage, child abuse, exposure to addiction, and other untoward experiences increase children's risk for various mental health problems, which can worsen and persist for a lifetime without treatment. I designed programs to prevent such outcomes for vulnerable children and adolescents. Most of my colleagues at the University of Washington, Ohio State, then Notre Dame devised treatments for existing mental health problems

experienced by adults, such as personality disorders, substance use disorders, anxiety disorders, and depression.

Despite years of extensive research by thousands of social scientists at hundreds of universities around the world, and despite the efforts of countless clinicians across various fields, a sizable fraction of people don't benefit from therapy. For others, however, it can be life changing. One of several reasons I stayed sober for thirteen years after outpatient treatment at age twenty-two was extended work in follow-up therapy. My primary therapist at the New Day Recovery Center in Portland ran her own, part-time private practice. After I was discharged from treatment, I started one-on-one therapy with her for an hour each week. This continued for a year before I tapered to fewer sessions for another year. Afterward, I was ready to negotiate life's challenges on my own, using the practices and principles I'd learned.

Although my therapist's competence in treating addiction was crucial to my continued sobriety, we spent almost no time discussing my recovery program. Once she knew I was committed to sobriety and engaged in a local recovery community, she rolled up her sleeves and got to work on deeper issues. Over the next two years, I came to understand and then resolve much of the confusion, insecurity, and resentment I carried from growing up with a severely compromised, bipolar mother and an angry, volatile father. I'd avoided the psychological and emotional fallout from these experiences since my first drink almost a decade before. Now it was time to face what I'd avoided. Although two years of therapy may seem excessive, "undoing" a lifetime of family dysfunction is formidable. Avoidant, fearful, and self-destructive behaviors acquired during childhood and adolescence are always difficult to change.

For those of us with histories like mine, long-term sobriety depends on dealing with early life trauma, which can only be processed effectively while we're sober. Moving forward with this crucial work early in sobriety can make the difference between relapse and lasting recovery. My therapist knew this, and was remarkably facile at balancing encouragement with candor. I needed positive feedback to remain in therapy given my sensitivity to rejection, but I also needed honest feedback to identify and change the dysfunctional thoughts and behaviors that were keeping me stuck in addiction. Because these thoughts and behaviors were second-nature, I couldn't see them for myself. Without my therapist's insights and direction, I likely couldn't have changed enough to stay sober for thirteen years. Moreover, had I honored what I learned and resumed therapy when the old thoughts and behaviors returned, I may have stayed sober for good. Seemingly

long-lost patterns of thinking and doing often rekindle after years of dormancy when we're placed under severe or protracted stress.

When I arrived in therapy, my major strength was academics. This gave me the skills and persistence to set clear goals and reach them, almost every time. Yet I was rudderless in my personal life, even when sober. I was hyper-competitive, narrow-minded, and afraid of deep interpersonal connections. I'd seen mostly conflict, not compromise; withdrawal, not approach; and reprisal, not grace. I had no idea how to be a loyal friend, an intimate partner, or a tolerant human being.

In two years of therapy all of this changed, and the next decade was the most satisfying of my life. With my therapist's guidance, I transformed into a reliable, principled partner and friend who cared about others and whose word was unfailing. Very little contemporary research addresses the painstaking work needed for such transformations. Without an active literature to turn to, my therapist, who had a master's degree in social work, leaned heavily on career experience and her own history in recovery, which she referenced rarely but strategically.

This life-changing experience in therapy inspired my career in clinical psychology. I wanted to do for others what my therapist did for me. When I attended college and dropped out twice before, my majors—chemistry and engineering—carried no meaning. Treating mental health problems did. I enrolled in the bachelor's degree program in psychology at Portland State University, with the long-term goal of earning a master's degree and becoming a therapist. Guided and encouraged by my undergraduate advisor, however, I applied to Ph.D. programs instead, seeking to become a practicing clinical psychologist.

Part of the application packet for any clinical psychology program is a written personal statement explaining one's interests in the field and inspiration for seeking graduate training. My first draft included a candid summary of the experiences I describe in this book, without the gritty details. Like any informed applicant, I asked my advisor to proofread my statement. She struck out every word about my mental health, my addiction, and my recovery. There was almost nothing left. I'd assumed my experiences—especially in recovery—would be assets in my training, yet I heeded her advice and rewrote my statement, knowing she had my best interests in mind. Years later, as a faculty member sitting on graduate student selection committees, I saw how prescient her advice was.

This first exposure to the culture of academic clinical psychology spoke volumes. My advisor, like all academic psychologists, knew that mental health

struggles—even when treated and in remission—were usually deal-breakers for admission to graduate school.* The next draft of my statement made no mention of my mental health, my addiction, or my recovery. Although the statement was compelling, it was built on a house of cards. I, like many successful applicants to clinical psychology Ph.D. programs, learned to hide my mental health challenges and to dupe others about my motives for pursuing graduate study *before I even walked in the door*.

Screening applicants out of graduate programs when they self-disclose mental health issues is a dubious objective that often fails and later backfires. Like me, affected students still gain admission, but they're driven into the closet, breeding shame, disconnection, and stigma. For some of us, secrecy and isolation set the stage for the schismed, double-life I later perfected—a life of concealment and pretense that fuels illness progression and recurrence. All in a field devoted to improving peoples' mental health and quality of life. This is one of several ways clinical psychology stigmatizes and marginalizes those within its ranks who experience mental illness. I discuss other ways below.

I was eventually accepted into the clinical psychology Ph.D. program at Stony Brook University, where I received very competent training in cognitive behavioral therapy, today's prevailing approach to treating mental health issues. The program's strong research emphasis, however, engaged my academic identity in ways I hadn't anticipated. During five years of graduate study, I gravitated slowly toward an academic career. There were three reasons for this. First, I was gifted at designing, conducting, and publishing research, which overshadowed my clinical inclinations. Much of my clinical work was supervised in groups—one faculty member with two or three graduate students. I saw first-hand that all of my classmates were, like me, competent clinicians. My clinical work therefore didn't stand out. My research, however, did, which engaged my ambition and canalized my academic identity.

Second, although many clients got better, others didn't, and one later suicided. Mixed treatment outcomes aren't unusual, even for seasoned clinicians, but before these experiences I'd assumed everyone progressed in therapy. Now I knew otherwise. Some clients, like Mom, were too impaired and had too little insight for meaningful or sustained recovery. Others, like me, refused medications, and some weren't sufficiently motivated. Some were court-ordered and disinterested, and

*By my observation, little has changed in thirty years.

still others dropped out. In my clinical work, success, as I defined it, wasn't assured. My research and writing projects, however, succeeded every time.

Third, the expansive and then still lengthy ups of my undiagnosed but advancing bipolar disorder inspired my creativity, fueled my productivity, and bolstered my ego. I accomplished more than all of my classmates, and I did most of it well. It's no coincidence that my deepening bipolar disorder and transition away from clinical work occurred in parallel with my slow retreat from the balanced humility of active recovery.

I didn't plan much less discuss my shifting priorities, and my bipolar disorder progressed outside my awareness. Both "just happened" in a person who's prone to self-reflection. How was this possible? Shouldn't self-awareness be coveted in a profession that trains students to impart self-awareness in others? Shouldn't students explore their own psychological dilemmas and maintain their own mental health during five years of graduate training? Don't these factors influence the way student therapists view clients, how they approach therapy, and how effective they are?

For me in particular, how was I to help others improve their mental health when mine, at least in retrospect, was slowly declining? Why wasn't I evaluating and maintaining my own psychological fitness, and exploring how my temperament and character engaged with and affected my clinical work and research in ways both restraining and beneficial?

To answer the first question, effects of therapists' mental health on their clinical work are far from straightforward. Depending on the mental health issue, therapists' effectiveness can be compromised, unchanged, or even enhanced. Active psychosis and active addiction clearly incapacitate by altering one's ability to make and maintain interpersonal connections and sound decisions. They also affect dependability. These can do harm.

At the same time, major advances in treating substance use disorders, bipolar disorder, borderline personality disorder, ADHD, and depression have been made by people affected by the very disorders they treat and study. Those of us with mental health problems know first-hand what patients and clients face, what coping strategies can be most helpful, and what research questions remain to be answered and addressed. Although researchers and practitioners without mental health struggles are often highly capable and empathic, they don't have the same deep-level understanding, or *lived experience* in today's terms.

The second question, why I didn't explore or nurture my own mental health during graduate school, can only be answered by elaborating the prevailing culture in academic clinical psychology. As I presage above, despite its ostensible purpose

of helping people live more satisfying and functional lives, academic clinical psychology often stigmatizes and marginalizes those within the field who suffer from mental illness.

Stigma is defined by negative attitudes toward people who are physically, mentally, or socially different than most members of a society or other social network. Although we usually think of stigma as a nationwide phenomenon,* it also arises in immediate and local social networks such as peer groups, church communities, and academic disciplines. Stigma ostracizes those who violate, intentionally or not, one or more of a social network's cultural values. Those with addiction and other forms of mental illness are treated as outsiders and carry an implicit "mark of shame".

Addiction is the most stigmatized mental health problem in the U.S., which works against recovery.[75] Like me, many people who know they need treatment for addiction avoid seeking help because they fear being stigmatized in their local communities. Addicts are also less likely than those with other ailments to disclose their addiction to medical providers, for good reason. National surveys completed by primary care doctors reveal biases against addiction, resulting in lower quality of care. Stigma adds to the shame and isolation addicts already experience, often leading to increased substance use and risk of suicide.[76]

One would expect less stigma in clinical psychology than in the public given its purpose of cultivating peoples' mental health, but such isn't the case. Rather, prejudice, discrimination, and stigma toward mental illness run deep in our discipline, and are strong deterrents to self-disclosure and treatment-seeking. Very few faculty members who struggle with mental health problems ever disclose them to colleagues—the very experts who should understand, accept, and have useful advice. Stigma also dissuades graduate students who struggle with mental health issues from disclosing them to faculty.

I taught in three top departments for almost twenty-five years. Then and now, when a mental health issue was revealed by or discovered in a student, the problem had often reached an advanced stage because the student hid it for some time to avoid stigma and associated shame. A cardinal rule of prevention and treatment is that immediate, early intervention offers the best chance for full and lasting recovery. As when treating infectious diseases, diabetes, or cancer, interventions work better before extensive damage is done. Later on, even intensive treatments are more likely to fail. Yet the often clear incentive for those in the field with

*Online social networks now extend stigma well beyond national borders.

mental health problems is to hide and wait in secrecy, hoping for a naturally occurring remission.

Never as a graduate student did I mention or disclose my mental health history to a faculty member, and only once did I disclose a carefully selected sample of my struggles to a fellow student. I'd already learned not to self-disclose when I wrote my personal statement. Not once did a fellow student mention their mental health to me, and not once did a faculty member disclose a weakness of any kind—mental health-related or otherwise—in one of my classes. The one faculty member we all knew had bipolar disorder was ridiculed behind his back by students and colleagues alike. This sent an especially potent message to stay in the closet. Yes, he was difficult and undiplomatic, but one might think these qualities would be placed in the proper context and met with compassion in a clinical psychology training program.* He later suicided.

In a more affirming clinical psychology culture, I'm certain I would have shared my mental health history and disclosed my recurring and deepening depressions. Instead, I was ashamed to seek treatment for what turned out to be increasingly severe bipolar disorder. Had I not feared stigma and reprisal, I may have been properly diagnosed and treated years before I was. Had it been safe to self-disclose my ever-kindling addiction and join a recovery community, I may not have relapsed. Of course I'll never know these things, and no individuals are to blame. The academic culture of clinical psychology is much larger than any person.

Ironically, most faculty members and graduate students strive to destigmatize mental illness, consistent with and directed by published priorities of the American Psychological Association. In classes, in supervision, and in advising, faculty say all the right things, and every scientific conference offers symposia on stigma reduction. Psychologists advise and initiate anti-stigma campaigns in schools, on television, in print media, and online. Clinical psychologists play central roles in writing and lobbying for anti-discrimination legislation. Some of us were intricately involved in formulating the Mental Health Parity and Addiction Equity Act,[77] which became law in 2008.

These are clearly admirable and worthwhile endeavors, but *within* academic culture and *within* clinical psychology training programs, our behavior is often subtly and sometimes palpably antithetical. I've been astonished in every graduate training program I've taught in by clinical faculty committee decisions about

*Like me, this faculty member had a baby daughter later in life. This became the subject of endless gossip and ridicule. Because he was different, he was stigmatized.

graduate students who self-disclosed psychiatric problems or were judged to have mental health issues, including ADHD, anxiety disorders, obsessive-compulsive disorder, and recurrent depression.

A common first step after learning a student is experiencing a mental health issue is to suspend their clinical privileges, so they can't harm clients. This is often pre-emptive—executed without evidence of compromised clinical work. At first glance such decisions may seem prudently precautious, but none of the mental health issues listed above necessarily interferes with clinical effectiveness, which is readily monitored in real-time. All programs videotape student-led therapy sessions for supervision purposes. Faculty can even watch sessions live. Suspending clinical privileges without evidence of students' ineffectiveness strips them of personal agency, an often crucial component of recovery from mental illness. However we choose to frame it, at least some students are penalized for their mental illnesses based on stereotypes of how they *might* behave.

Over the years I've seen several students with mental health problems ousted from clinical psychology training programs for failing to meet standard timetables toward completing degree requirements such as classes, theses, and dissertations. Several of these students revealed their mental health problem only after they were confronted with their unsatisfactory progress. When adjudicating their cases, faculty committees sometimes considered their mental health and devised remediation plans, but at other times expelled them or strongly encouraged them to leave.

These cases are particularly troubling given an academic culture that encourages concealment and therefore shame. Students isolate to maintain secrecy and avoid the stigma almost all of us either experience or sense but often deny. By the time they're "found out", the optimal window for early intervention is often passed. I've seen some of these faculty decisions reversed only after students sought outside legal counsel. This places an enormous burden of stress on students who already suffer from a mental health condition. Stress accrues moving forward as students wonder which faculty members voted for versus against their ouster.

Students sometimes face physical ailments and other life circumstances while in graduate school. Things like car accidents, cancer, pregnancy, and more. In these circumstances, a student occasionally reprioritizes and departs a program voluntarily, but I've never seen one forced out or strongly encouraged to leave for "performance issues" arising from their condition.

To be sure, there are rare, unfortunate cases in which worsening mental health problems preclude careers in clinical psychology. Yet it's nakedly paternalistic for

the field to champion anti-stigma and anti-discrimination agendas, and to encourage and even legislate anti-stigma and anti-discrimination policies that affect other institutions, when we continue to stigmatize and marginalize our own. I'm told by colleagues who work in especially progressive programs that change may be coming. The *neurodiversity* movement, for example, is more accepting and accommodating of ADHD among students.

Faculty members are also affected. With stigma ever-looming, few disclose their mental health struggles, and most avoid public recovery spaces. I've worked in three large departments in cities big and small. As in graduate school, I've never revealed my mental health struggles or addiction, and I've never had a fellow faculty member reveal a mental health issue to me. Not once have I encountered a psychology colleague in a local recovery space. I've met exactly one practicing psychologist who wasn't in academia, and no psychology fellows or graduate students.

However unlikely, it's possible that none of the few hundred such people I've known during my career has suffered from alcoholism or another addiction. Or perhaps none of them yet suffered from advanced addiction. Or maybe those who did occupied different recovery spaces. What we do know is that addiction to alcohol and drugs affects nearly twenty percent of people in the U.S. at some point in their lives, and that rates of addiction vary little across career categories or social class.

I've come to know many recovering faculty members, graduate students, and postdoctoral fellows in *other* academic disciplines, including anesthesiology, art, biochemistry, English, family medicine, internal medicine, music, neuroscience, oncology, religious studies, social work, sociology, theology, veterinary medicine, and more. In a few of these disciplines I've known several recovering students and faculty members. Every week I see or speak with at least one.

I've known recovering professionals in occupations where knowledge of their addiction could be costly—attorneys, pilots, and politicians. Yet among the hundreds of people in my field I've met in twenty-five years, I've seen only one practicing clinical psychologist in a recovery space. There are no explicit rules in our profession precluding us from occupying these spaces. Rather, there are implicit cultural rule structures that few are willing to breach.

For readers who might remain skeptical about stigma being rooted so deeply in academic clinical psychology, consider my current situation. In twenty-five years in academia, I published almost three hundred scientific papers and book chapters, edited five books, and received tens of millions of dollars in federal grants. I

received prestigious national awards from the American Psychological Association for both early- and mid-career achievement, and I received university and department awards for undergraduate teaching, undergraduate and graduate student advising, and postdoctoral mentorship. Yet I state with certainty I will never and could never work in academia again—even if I sought to with years of recovery—after publishing a candid memoir about my addiction and bipolar disorder. Why? And how might things be different if my memoir were about recovery from life-threatening cancer?

In the last two decades, cultural views of some mental illnesses have improved in the U.S. Although considerable stigma remains, national surveys show promising downward trends in prejudice and discrimination toward those with depression, for example.[78] Unfortunately, stigma has increased toward those with schizophrenia, substance use disorders, and all forms of addiction.

There are no surveys on trends in stigma toward mental illness or addiction specifically within academic clinical psychology, yet as I describe above, prejudice, discrimination, and stigma remain deeply embedded in academic culture.[79] Cultures are difficult to change, and when they do it tends to happen slowly. Whether local, societal or in between, cultural rules for thinking and behavior are largely implicit and unlabeled—learned not through words but through the attitudes, actions, and examples set by those around us. What's open for discussion and what's taboo. What form of addiction is most despicable. Whether addiction is viewed as an illness or a character flaw. These rules are passed down from generations who come before us, and are powerful because they're largely invisible—adhered to and enacted outside our awareness. Change requires us to label, analyze, and confront these rules.

I've never met an actor in academic clinical psychology who sought to stigmatize mental illness. Most of us hold fully opposite values and most of us are doing the best we can, based on our own ideals and our common understanding of our field's stated priorities. Although the American Psychological Association places destigmatizing mental illness near the top of its public agenda, its targets for destigmatization are primarily societal and institutional. This doesn't address how we stigmatize our own.*

Regardless of the mental health problem, research shows that destigmatization requires us to educate members of stigmatizing groups, to humanize mental illness

*A few influential advocates, most notably Mitch Prinstein, Chief Science Officer at the American Psychological Association, have championed change. Hopefully, this portends future improvement.

by having well-known people self-disclose, and to put these people in face to face contact with both those who stigmatize and those affected by mental illness.[80] To minimize stigma in clinical psychology, people within the academy must come out, take their message to the classroom and the public, and interact one on one with others in our discipline and beyond. If education alone were enough, we'd have no stigma problem. Inroads, however, require much more than mere knowledge. Reversing stigma requires faculty, like me, to share our stories and our pathways to recovery, putting a vulnerable human face on addiction and other mental illnesses.

I'm privileged to know two academic clinical psychologists, both friends, who've done these things, and confronted stigma in clinical psychology and beyond. Both are towering figures in the field who self-disclosed, educating colleagues and the public, and humanizing mental illness, but in very different ways.

One of my great career fortunes was to join the University of Washington faculty in 2000 and become a colleague of Marsha Linehan's. Marsha suffered from and devised an effective treatment for borderline personality disorder. People who struggle with borderline personality disorder feel empty, fear abandonment, and experience uncontrollable negative emotions, including fear, panic and anger, when they believe their emotional wellbeing is in peril. Nearly one in three people with borderline personality disorder attempts suicide.

For years, borderline personality disorder was considered untreatable. Then Marsha, pulling from her academic training, her formidable clinical skills, and her lived experience, devised a new approach—Dialectical Behavior Therapy (DBT).[81] DBT reaches people who couldn't be reached before. Marsha brought new hope to her clients, their families, and their friends where little existed before.

In 2011, over twenty-five years after her first writings about DBT and two years after I left the University of Washington, Marsha "came out" in a *New York Times* article as having suffered from borderline personality disorder and recovered. Without Marsha's lived experience informing her treatment development, the world would be without DBT, which has helped tens of thousands of adults and adolescents and saved many lives. *Had Marsha come out before or during graduate school, or before she was an established leader in the field, her career would likely have ended before it began.* Marsha, like me and others, hid her mental health problems for years because it was necessary to be taken seriously in a field that stigmatizes and marginalizes its own.

Marsha is a gifted clinician with an incisive intellect. I collaborated with her on a National Institute of Mental Health grant to adapt DBT for women with borderline personality disorder and opioid addiction. I attended her group's weekly lab meetings and strategic planning sessions for research. There and elsewhere, Marsha taught me many of the ins and outs of writing successful grant applications and succeeding in academia. She communicates directly, with bluntness that belies her academic position and career stature. More than once I felt offended by her candid feedback, but it made me a stronger academic and a more compassionate person. I understood she cared about my wellbeing and was invested in my success. She was also deeply invested in the success of our training program.

For reasons that perplexed me at the time, Marsha, the most influential clinical psychologist at the University of Washington—a perennial top five training program—was often marginalized by other faculty. Despite her profound influence on the field, millions of dollars in federal grants, and countless publications in top journals, she was among our lowest paid professors. Marsha was underpaid because she was ostracized in her home department,* where conformity and complaisance trumped influence and productivity. Her annual peer ratings, which helped determine raises, kept her salary low.

Marsha was different. She was plain-spoken, direct, and unwilling to "go along" for the sakes of amity and the status quo. This becomes problematic in academia, where—at least in all departments I've worked in—conformity is prioritized over impact, productivity, and creativity. Marsha wasn't tactful or obliging. Well before she came out in 2011, others saw her as contrary and difficult, so they marginalized her. I watched colleagues turn to one another in faculty meetings and roll their eyes when Marsha spoke. She was gossiped about behind her back by students and faculty alike, and her accomplishments were discounted. She was punished for the very traits that made her vulnerable to mental illness, by those in a field dedicated to treating it. Nevertheless, Marsha reduced stigma toward borderline personality disorder by coming out and being willing to pay an undue price.

The second colleague and friend who's persistently confronted stigma in the field is Steve Hinshaw, professor and former chair of Psychology at the University of California Berkely. I met Steve in 2001, when he visited the University of Washington to give an invited lecture on ADHD, one of his core areas of

*Sexism was not the explanation for Marsha's salary. Two of the highest paid professors in the department were highly productive and influential women.

expertise. As a newly hired assistant professor with overlapping interests, I was assigned as Steve's host. I was supposed to pick him up at the airport, but I was late so he took a cab, something I'd forgotten until he reminded me after reading this chapter. Fortunately, Steve took this in stride. Our informal conversation driving back to SeaTac for his return flight started our now twenty-five year friendship.

During Steve's visit we had the first of many conversations about mental illness within our families. Steve's 2002 book, *The Years of Silence Are Past: My Father's Life With Bipolar Disorder*, would soon hit the press. Steve mailed me a copy, which I read with great interest given Mom's mental illness and its lifelong effects on me. Steve described how, as a child, he blamed himself for his father's erratic behaviors—feelings I well understood. This self-disclosure and others in Steve's books, and our many conversations that followed, laid a foundation of trust I've experienced with no other person outside a recovery community, and only one other person in academia. Steve is one of five people, including Kari, who I've shared my full story with. He recently visited us in Columbus after hearing of my decision to leave the field.[#] Outside of an occasional Zoom meeting, I hadn't seen Steve face to face in several years. I felt instantly at ease as his car entered the driveway.

Steve's academic, institutional, and public policy work have contributed greatly to the twenty-year downward trend in stigma for some disorders, as I mention above. This painstaking professional work is essential if we're to effectively challenge the stigma culture in academic clinical psychology and beyond. Yet Steve's poignant self-disclosures—not his academic writings or public policy work—are what gained my trust.[*] When someone highly visible, like Steve, self-discloses, it humanizes mental illness and gives others, like me, permission to do the same. Steve's most recent 2017 book, *Another Kind of Madness: A Journey Through the Stigma and Hope of Mental Illness*, further details his experiences growing up with a father affected by bipolar disorder. I found it especially moving.

[#]Steve's visit was in the spring after my treatment.

[*]I don't mean to understate Steve's formative contributions to science, or the influence his work had on my early professional development. Steve directed the Berkeley site of the Multimodal Treatment of ADHD study——the largest NIH grant ever funded to compare different treatments for ADHD. Steve also directs the Berkeley Girls with ADHD Longitudinal Study, the first to explore how ADHD develops from elementary school through young adulthood specifically for girls/women. Steve's work provided go-to models for the field, and for me as I designed my own treatment trials.

In clinical psychology and its allied professions, the *mere act* of studying mental illness dehumanizes, often deepening stigma. Scientific papers, regardless of who writes them and regardless of their motive or intent, objectify. This isn't a value judgement. Objectification is inescapable because mental illness is and has to be the object of our scientific writing. Such is *always* the case when we use language to communicate about events outside ourselves—a curiosity philosophers of science have recognized for over a century. When we share information about external events with other scientists, language is all we have.

Don't get me wrong—scientific papers about mental illness give it the attention it deserves, teaching us about causes, trends, and possible solutions. This work is crucial. Nonetheless, mental illness becomes a disembodied entity—a "thing" separated from the human beings it affects. Human beings we've never met and don't know. Yet when someone self-discloses, they and their mental illness become the *subjects* of their speech and writing. Listeners and readers come to know the person who's affected. Mental illness becomes embodied and humanized. Scientific writing, however necessary, can't do this, so alone it's never enough.

A common refrain in the helping professions is that we're not defined by our mental illness, our addiction, our disability, or what have you. The sentiment behind these statements is almost always well-intentioned, and surely we're not fully defined by our foibles or frailties. Yet if stigma were eradicated, there would be no need for such statements. We could embrace our mental illness, not reject it. These traits would be mere parts of us—not our foibles or frailties. When we reject being defined by a core, enduring part of ourselves, we reinforce our own negative views of mental illness and internalize shame. Although our intentions are just the opposite, we stigmatize yet again.

Mental illness doesn't exist outside our human experience. I tried for over thirty years to define myself independent of my bipolar disorder and my addiction. This quest produced a schismed self so damaging to my mental health it almost killed me. Through this I've come to believe I can't be defined *without* referencing my mental illness and addiction. As I edit this chapter one last time it's been two and a half years since I checked myself into treatment. Coming to terms with my mental illness and addiction by writing this book has me more in touch with my humanity than I've been since my thirteen-year recovery as a younger man.

Radical acceptance is a concept in Dialectical Behavior Therapy that encourages us to embrace ourselves for who we are and the world around us for what it is. For over three decades I rejected parts of myself that define who I am, seeking, at

any cost, to cast myself in terms other than mental illness and addiction. In doing so I gave them more power, not less. Mental illness and addiction are parts of me. I've been most content in life when I accept this—when I embrace the God-given limitations and incapacities that are just as much a part of me as my God-given strengths and talents.

Human beings are social creatures by nature. We internalize the judgments and expectations of those around us. When self-disclosure of mental illness is taboo—as it often is in academic clinical psychology—we receive a potent message of judgment and stigma. And when we conform by maintaining secrecy, we pass that potent message forward to the next generation. In today's academic culture, mental illness is a legitimate topic of scientific study and a worthwhile target for treatment and prevention, but it's unacceptable for us to experience or express. This paternalism sets a destructive example, spawning stigma and diminishing rather than elevating the value of our work. If clinical psychology is to achieve its stated goals, more of us, like Marsha and Steve, need to self-disclose.

My first foray into self-disclosure was in Steve's 2008 book, *Breaking the Silence: Mental Health Professionals Disclose Their Personal and Family Experiences of Mental Illness. Breaking the Silence* stands alone as a compendium of self-disclosures by people in the field. I contributed a candid, raw chapter about growing up with a mentally ill mother. For years I felt guilty about writing it; I should have preserved the family secret. In truth, I still feel that way. What bothers me more is that I took the easy way out—describing Mom's struggles and my reactions to them while saying nothing about my own mental illness or addiction. I was far too afraid of stigma and its consequences for my then fledgling career. If I were at the same point in my career and confronted with the same decision today, I'd make the same choice because so little has changed. Thankfully my career is behind me and I don't face that situation. I hope by coming out I might make a small contribution to change.